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.

Facts and data about this trust

Hampshire Hospitals NHS Foundation Trust was established in January 2012 as the result of the integration of Basingstoke and North Hampshire NHS Foundation Trust and Winchester and Eastleigh Healthcare Trust. The Trust provides general hospital and some specialist services to a population of approximately 600,000 people in North and Mid Hampshire, and to patients from much further afield for some specialist services. The population is predominantly rural, with urban areas in Basingstoke, Winchester, Andover, Eastleigh and Alton.

Hampshire is comparatively affluent with some small pockets of deprivation and is aging more rapidly than the national average. There is a predicted 29% increase in the over 85’s in the seven years between 2016 and 2023.

Hampshire Hospitals NHS Foundation Trust provides services from three main sites, Basingstoke and North Hampshire Hospital (BNHH) in Basingstoke, the Royal Hampshire County Hospital (RHCH) in Winchester, Andover War Memorial Hospital. BNHH and RHCH provide a full range of planned and emergency district general hospital services, including a 24-hour accident and emergency, general and specialist surgery, general medicine, intensive care, rehabilitation, chemotherapy, diagnostic services, maternity, neonatal, gynaecology, paediatric care and outpatient clinics.
BNHH provide some specialist services to people across the UK and internationally. They are one of two centres in the UK treating pseudomyxoma peritonei (a rare form of abdominal cancer) and provide tertiary liver and colorectal cancer services as well as the haemophilia service. RHCH pioneered the use of intraoperative radiotherapy for breast cancer treatment.

Andover War Memorial Hospital (AWMH) provides community and hospital services including a minor injuries unit, outpatient clinics, diagnostic imaging, day surgery, rehabilitation and midwife led maternity services.

Hampshire Hospitals NHS Foundation Trust also provides outpatient and assessment services from Bordon and Alton community hospitals.

The majority of services are commissioned by North Hampshire Clinical Commissioning Group (CCG) and West Hampshire CCG, but the trust also has some nationally commissioned services run from the Basingstoke site and a growing number of patients from West Berkshire CCG.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

In 2017/18 the trust had 125,007 emergency attendances, 599,418 outpatient attendances and 5236 babies were born at their hospitals, birthing units or at home.

The trust is registered to provide the activities of:

Treatment of disease disorder or injury.
Assessment or medical treatment of persons detained under the Mental Health Act 1983
Surgical procedures
Diagnostic or screening procedures.
Maternity and midwife services
Termination of pregnancies
Family planning

Hospital sites at the trust

A list of the hospitals at the trust is below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and North Hampshire Hospital</td>
<td>Aldermaston Road, Basingstoke, RG24 9NA</td>
</tr>
<tr>
<td>Royal Hampshire County Hospital</td>
<td>Romsey Road, Winchester, SO22 5DG</td>
</tr>
<tr>
<td>Andover War Memorial Hospital</td>
<td>Charlton Road, Andover, SP10 3LB</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites)

To write this well-led report, and rate the organisation, we interviewed both executive and non-executive directors, governors and a range of senior staff across the hospital. This included a range of clinical and non-clinical service and specialty 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, strategic plans, audits and action plans, board meeting minutes and papers to the board, investigations and feedback from patients, local people and stakeholders, including NHS Improvement (NHSI).
Is this organisation well-led?

Leadership

The executive team had a range of skills, knowledge and experience. Some executives had been in post for significant periods of time, while others had been appointed in the previous 12 months, which had brought new ideas and different ways of working to the team. We were not assured that the leadership had a focus on quality and safety, as we had seen a deterioration in the quality of care since our last inspection.

The Chief Executive Officer (CEO) has been in post 15 months, she was stated to be visible and demonstrated the trust’s values. The trust had appointed an experience director of people, who had been well received by both the board and staff who spoke positively about her. This new role was seen by the trust as pivotal in leading the organisational development and facilitating fair and consistent human resource (HR) processes. The trust’s chief nurse (CN) is due to retire in September 2018 and her replacement, an experience director of nursing will take up post at that time.

The trust chair had been in post for several years and is stepping down in December 2018, following our inspection we were informed that a replacement chair had been appointed. The non-executives (NED) had a variety of backgrounds and experience, with a number of them having professional financial backgrounds. There were no NED’s with a clinical background and this meant there was an absence of independent clinical challenge at board level. While this was acknowledged there was no mitigation in place to address this in order to have a range of skills and input into the board.

We were told by several members of the executive team and the NEDs that appropriate challenge took place at board and executive meetings. However, the minutes of these meetings were brief and did not summarise these discussions, only the discussion outcomes, and did not provide evidence that constructive challenge took place. While staff involved were aware of the discussions that took place, this resulted in a lack of information for those not present at board and a lack of evidence if there was a query at a later date regarding what was discussed or the rationale for decisions.

It was reported that NHS Improvement (NHSI) and the CCGs were critical friends to the trust, providing appropriate challenge. However, the trust did not evidence or when asked provide examples of challenges and the impact these had on decisions or practice. Following our inspection, the trust provided examples of challenges that had resulted in changes these included; a challenge from the CCG to share learning from incidents more widely. In response to this the trust organised a never event conference which was attended by staff from across the local care system.

As a Foundation Trust there was a council of governors (CoG). We spoke with some of the governors who reported the CEO was approachable, they described their relationship with the executives as professional and that they had positive partnership working across directorates. The CoG were encouraged to participate in safety walk arounds, attend quarterly meetings with the executives and received quarterly reports from the board meetings.

An external review of the trust’s leadership had been undertaken and an action plan had been developed in response to the recommendations made to improve leadership in the trust. However, staff we spoke with were unable to provide specific examples of actions that had been taken and the impact these had had on improving leadership within the trust. It was reported progress against the action plan was discussed regularly at board meetings. However, this progress was
only presented verbally and not presented in a written report. As the board minutes were very brief they did not detail the reasons for actions not being completed or the impact of action taken.

There was a lack of compliance by the trust with meeting the Fit and Proper Person Requirement (FPPR) (Regulation 5, HSCA, 2014). We found on this inspection that there was a lack of an effective system to review fit and proper persons being employed. The trust stated it was satisfied that staff with director level responsibilities, including the NEDs, were fit and proper persons in accordance with Regulation 5 and checks were carried out in line with their Fit and Proper Person (FPP) policy. We reviewed four executive and two NED files plus the file of the chairperson to assess compliance with the Fit and Proper Person Requirement Regulation. Overall, we found that this was not being managed effectively, because qualifications, Disclosure and Barring Service (DBS) clearance, written references, disqualified director’s and insolvency checks and information on the recruitment process were missing from some files. Completed occupational health screening was included in most files however in two files the occupational health screening referred to a previous job role and therefore may not have been relevant to their current role.

We reviewed paper based personal files and human resources records which were printed from an electronic system to review further information. Some personal paper files were disorganised and did not include a FPPR checklist to clearly identify if the information was included and where it was. Some files did have an FPPR checklist but these were not fully completed. The HR files we were provided with, included some additional information such as appraisal documentation for the executives and a job description and recruitment process for the CEO. There was evidence in some files that telephone reference checks were completed for some new executives. We were told these were in addition to written references to make sure that information could be verified and discussed so checks were comprehensive.

Overall responsibility for FPPR was held by the chairperson, who delegated this responsibility to the company secretary. The chairperson told us they were confident that the FPPR regulation was complied with. We were told that completion of the checks on appointment and yearly reviews were the responsibility of the trust company secretary. However, on speaking to this individual they did not see this as their responsibility and stated it was the HR team who were responsible for ensuring annual reviews were completed. Following our inspection, the trust confirmed the only element of the annual FPPR the company secretary competed was the director’s disqualification and insolvency checks.

During our core service inspection, we identified issues that if not addressed in a timely manner would negatively impact on the quality and safety of care received by patients. For example, in the emergency department we identified that there was a lack of effective systems to assess and monitor on going care and treatment, this meant deteriorating patients may not be identified in a timely manner and appropriate care provided. The executives were not aware of these issues until they were raised with them. We were not assured that the trust leadership team fully understood the current challenges to quality and sustainability.

Directors, NEDs and governors undertook regular safety walk arounds at all three sites. While some staff said some members of the executive team were not visible, we saw written feedback following these walk arounds that had been sent to the clinical matron. It was reported the CEO was open and receptive to ideas and change with many staff who we spoke with feeling able to contact her directly and we were provided of examples of when they had done so. However, some middle managers said that by staff going directly to the CEO they were not always provided with an opportunity to resolve issues before they were escalated to the CEO.

The current clinical leadership model was unique, primarily led by a medical leadership model. The divisional management team was not a triumvirate with nursing, medical and operations identified as the senior management team. Instead there were nursing inputs via performance reviews and divisional governance meetings but they had limited influence in relation to service development and service leadership in some divisions. While the trust’s view was that nursing did
have a voice in the divisional senior leadership team, the model was medically focused with strong medical leadership and did not encourage joint working.

The trust had introduced clinical matrons in April 2016, with the aim of empowering these individuals to develop their clinical areas, utilising their budget to deliver care and drive improvements. It was reported their capability and effectiveness was variable across the trust, a view supported by our core service inspection findings. The role was currently being reviewed by the CN to evaluate their impact. It was acknowledged that if the clinical matrons are to deliver the proposed improvements they will require support and development, which is currently being provided. The clinical matrons have access to monthly action learning sets and their annual appraisal is completed by the CN. The director of people had started work on leadership development programmes and succession planning, including a structured programme for the clinical matrons. However, opportunities for staff below team manager level required further development. Staff wishing to progress to a ward manager were not provided with opportunities to develop into this role.

The divisional medical directors were keen to develop and were reported to be open to change. As a team they had started to introduce changes in their areas and trust wide. For example, they had introduced a new medical rota that provides visibility of the location and activity of individuals, such as when they are in clinic, on annual leave or study leave, promoting transparency.

**Board Members**

There were no Black and Minority Ethnicity (BME) members of the board at both executive and non-executive levels. Of the executive board members at the trust 60% were female, and 29% of the non-executive board members 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%</td>
<td>60%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>29%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>42%</td>
</tr>
</tbody>
</table>

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

The trust was aware that the board lacked cultural diversity.

**Vision and strategy**

- The trust stated they had a clear vision and values which had been communicated throughout the organisation. These were underpinned by detailed strategies which provided the framework for the operational plan.
- Arrangements were in place for reporting the cost improvement plan (CIP) programme. All schemes had an executive sponsor and a workstream lead. PMO arrangements were in place to manage the delivery of the programme.
- The trust had a counter fraud strategy in place which was led by the nominated Local Counter Fraud Specialist (LCFS). The work of the LCFS was overseen by the Audit Committee.
- The trust had recently introduced a monthly CIP board chaired by the CEO which monitored the delivery of the 20 highest value schemes.
- All CIPs went through a Quality Impact Assessment process including sign off by CMO/CN.

(Source: NHSI Finance assessment June 2018)
The trust had an overarching vision which was ‘to provide outstanding care for every patient’. The trust’s strategic framework stated four organisational goals, which together aimed to deliver the vision.

Following the decision by the CCG and others that the plan for a new clinical treatment hospital was unaffordable the trust recognised it had to revise its operational plan to address the trust’s aging estate, its clinical sustainability and underlying structural deficit and develop a clear strategic direction. Many staff we spoke with stated that the trust had focused on the development of a new hospital and therefore were only now developing a strategy including priorities for the development of services on the current estate. In November 2017 work commenced to develop a five-year clinical strategy and re-defining the direction of the organisation. This included discussions with senior managers including clinical directors and clinical matrons. However, many staff not in senior manager positions reported that they were not involved in the development of the strategic framework or other strategies and considered the trust’s approach to be a very ‘top down’ process. The draft strategic framework was emailed to all staff for comment and was also highlighted in ‘In Touch’. However, not all staff have access to emails and therefore these staff reported feeling excluded from participating in commenting on the document. Those that had commented on the document, stated that they had received a response to their comments.

In March 2018 the strategic framework was launched, this provided a 12-month plan with operational priorities, each with an identified accountable executive and target. To support the achievement of these priorities the trust have submitted bids to the sustainability and transformational partnership (STP) to fund specific service developments, these include redesign of the emergency department (ED), a cancer treatment centre and increasing the capacity of orthopaedics. Monthly monitoring of operational priorities takes place including identifying the risk to not achieving year end delivery. The success of delivering some of the operational priorities was dependent on the STP bids being successful, there was no mitigation to manage the risk if any of the STP bids were unsuccessful. It was not clear how the strategic framework was linked into other strategies and therefore there was a risk of conflicting priorities or actions.

While most staff were aware of the trust’s values, frontline staff were unclear about how its vision and strategic framework applied to the work of their team. The trust was starting to promote the strategic framework through the CEO’s regular newsletter and other initiatives but at the time of our inspection many frontline staff were unclear about the direction of the trust following the failure to secure funding for a new hospital.

The organisational development and leadership strategy aimed to support the delivery of the trust’s strategy, vision, and reflected its values. It identified how this would be achieved including changing the culture of the organisation and the benefits of doing so. There were clear objectives with timescales and monitoring arrangements in the document. This aimed to ensure that there were clear expectations for staff with an identified timeline. The document was produced following engagement with a trust who had successfully changed their culture and developed leadership capability, demonstrating the trust is using the experience and knowledge of others.

The pharmacy senior leadership team had a clear vision and strategy for the pharmacy department going forward. There was a focus on patient facing roles and plans for automation at the Basingstoke site and in some of the departments such as ED.

**Culture**

The trust had a clear set of values which staff were made aware of at induction and these are reinforced through ‘In Touch’ and appraisals. The majority of the divisional management teams promoted a common purpose based on the trust’s values.

Not all staff felt supported, respected and valued. As per NHS guidelines, the trust had a freedom to speak up guardian (FTSUG) whom staff could talk to if they had concerns. The trust had
appointed four FTSUG in 2017 who were all staff governors, and recently appointed a support guardian. The FTSUG stated they had recently attended the board to provide an update. They could provide some examples of this role working effectively to resolve issues. The guardian role was being promoted at induction and on the intranet but was not yet embedded into the trust. We were told not all staff were aware or felt confident in approaching these individuals for support. To encourage staff to use the FTSUGs there were information booths at all sites and a timetable of when FTSUG would be visiting the site including out of hours to ensure all staff were aware of their role.

Since the introduction of the role in 2017, it was stated the majority of the concerns raised related to staff behaviour. Between April- June 2017, eight cases had been raised. Two of these cases had an element of patient safety or quality and three related to bullying and harassment.

Staff were also encouraged to raise concerns through a range of ways including face to face, email, telephone or through the trust’s internal reporting system ‘speak up in confidence’. The web form allowed staff to raise a concern anonymously, which they could request was sent to a specific director to respond to. We were told that this was well used by staff, the information provided by the trust showed that 22 concerns had been raised between March 2017-2018.

Whilst the national staff survey reported that the percentage of staff experiencing harassment, bullying or abuse in the last 12 months was the same as other acute trust, feedback from various staff groups and whistle blowers who contacted us during our inspection, raised concerns that there was a culture of bullying and harassment which the trust had recognised but needed to address. Several members of staff we spoke with prior to and during our inspection reported that not all board members demonstrated the trust’s values and their behaviour was not challenged. This demonstrated that not all senior staff were exhibiting the trust’s values and concerns about bullying and harassment remain.

Staff stated that the director of people was keen to address this behaviour ensuring a fair and just culture was developed and staff at all levels were challenged if they did not act in line with the trust’s values. With the recent changes in the executive team and a new chair to be appointed, staff saw this as an opportunity to bring in change and develop a culture where staff hold each other accountable. Staff reported that bullying and harassment had been raised with the board and the director of people was exploring how to address this.

The trust provided bullying and harassment training and a tool kit was available to assist managers across the trust deal with issues. Staff expressed a view that this training should be extended to staff in specific areas that the trust were aware bullying was taking place in. This would not only ensure that staff were aware that the trust will not tolerate bullying but provide staff in these areas with the skills and knowledge to deal with bullying effectively.

We held a meeting with the trust’s governors which also included staff governors. They told us that they believed the trust culture was embedded at management level. During their safety walk arounds, they received consistent positive feedback from the patients and relatives about the standard of care they or their relative had received.

Some systems and processes such as incident reporting were standardised across the trust. However, other processes such as how and the timing in the month of off duties being developed and how patients were booked onto theatre list were not undertaken in a consistent manner. This resulted in resources not always being fully utilised. While this allowed individual areas flexibility it was acknowledged that specific processes needed to be standardised. This standardisation will commence with a new nursing rota being introduced, this will ensure all rota's are signed off on the same day and cover the same period. This will assist with planning staffing and identifying staffing issues trust wide.
We reviewed a random sample of 10 investigations following incidents of moderate or serious harm. Using our reporting tool, we concluded there was a process for the investigation but this process did not include a standard root cause analysis approach, we noted three different approaches in the cases we reviewed such as five-way technique, decision tree and brainstorming. All the investigation reports provided were still in draft form despite the incidents occurring over 12 months ago and they did not include an executive summary. There were only two reports with evidence that the patient/family had any input into setting the scope of the investigation. We found all investigations included a record of the Duty of Candour (DoC) lead and details of the notification that DoC had taken place. There were not always immediate letters sent for the DoC process and in one case no DoC letter was sent. There was always a plan to share the outcome of the investigation with the patient/relatives/family, but no record that this has occurred.

We found staff involved in the incident were engaged in the investigation process in a variety of ways usually through meetings. There was no evidence that formal interviews were undertaken to seek the facts and staff’s account of what occurred. Support was available to staff, usually provided by their line manager. All investigation reports included recommendations and identified learning that usually took place via the divisional structure. Following the investigation an action plan with time scales and how these were to be monitored was developed.

All directors, NEDs and staff we spoke with were proud to work in the trust. However, some said they were frustrated as when they reported issues or incidents they did not always receive feedback or the issue was not resolved. Staff stated this lack of feedback influenced their decision to report incidents in the future.

All staff were expected to participate in annual appraisals. At the time of inspection, the nursing appraisal rate was 66% which was below the trust’s target of 80%. The medical staff all stated that they had a job plan and had participated in an appraisal. Some other staff groups reported that due to their manager’s capacity they had not received their annual appraisal and therefore had not had an opportunity to discuss their learning and development needs. It was reported that the trust were currently looking at their approach to appraisal to improve this and make it more meaningful and linked to education. The trust had a talent spotting process but staff reported that this was not consistently applied and that if they did not have a positive relationship with their manager their potential talent was not recognised and they were not provided with opportunities to develop.

The trust recently held a ‘Staff Focus’ week during which a range of events were held to celebrate staff’s contribution to the trust and supporting patients. These included drop in career clinics, information about staff benefits and senior staff being encouraged to visit departments they would not normally interact with. These events received positive feedback from staff with a request this happened on a regular basis.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental staff, qualified nursing and health visiting staff and nursing and midwifery staff by ethnic group:

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing and health visiting staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>62.5%</td>
<td>62.7%</td>
<td>80.1%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.7%</td>
<td>0.6%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>14.7%</td>
<td>8.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Black</td>
<td>1.7%</td>
<td>4.1%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
The number of staff from BME backgrounds was largely reflective of the local population. However, at inspection we found BME staff were under-represented in senior leadership positions including board level positions and other senior leadership posts.

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

The trust has 20 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>3.18</td>
<td>3.11</td>
</tr>
<tr>
<td>KF21. Percentage of staff believing the organisation provides equal</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td>opportunities for career progression/promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF28. Percentage of staff witnessing potentially harmful errors, near</td>
<td>28%</td>
<td>31%</td>
</tr>
<tr>
<td>misses or incidents in the last month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness or procedures for reporting errors, near</td>
<td>3.81</td>
<td>3.73</td>
</tr>
<tr>
<td>misses and incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.73</td>
<td>3.65</td>
</tr>
<tr>
<td>KF17. Percentage of staff feeling unwell due to work related stress in the</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>last 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF18. Percentage of staff attending work in last three months despite</td>
<td>51%</td>
<td>52%</td>
</tr>
<tr>
<td>feeling unwell because they felt pressure from their manager, colleague or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>themselves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and</td>
<td>3.69</td>
<td>3.62</td>
</tr>
<tr>
<td>wellbeing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF15. Percentage of staff satisfied with the opportunities for flexible</td>
<td>54%</td>
<td>51%</td>
</tr>
<tr>
<td>working patterns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive</td>
<td>3.87</td>
<td>3.75</td>
</tr>
<tr>
<td>treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.94</td>
<td>3.92</td>
</tr>
<tr>
<td>KF7. Percentage of staff able to contribute towards improvements at work</td>
<td>73%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.94</td>
<td>3.91</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.52</td>
<td>3.45</td>
</tr>
<tr>
<td>KF6. Percentage of staff reporting good communication between senior</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>management and staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF3. Percentage of staff agreeing that their role makes a difference to</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>patients/service users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF32. Effective use of patient/service user feedback</td>
<td>3.81</td>
<td>3.71</td>
</tr>
<tr>
<td>KF22. Percentage of staff experiencing physical violence from patients,</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>relatives or the public in the last 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF23. Percentage of staff experiencing physical violence from staff in the</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>last 12 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. Percentage of staff appraised in the last 12 months</td>
<td>78%</td>
<td>86%</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.04</td>
<td>4.05</td>
</tr>
<tr>
<td>KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>KF16. Percentage of staff working extra hours</td>
<td>75%</td>
<td>72%</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.71</td>
<td>3.72</td>
</tr>
<tr>
<td>KF24. Percentage of staff reporting most recent experience of violence</td>
<td>61%</td>
<td>66%</td>
</tr>
<tr>
<td>KF27. Percentage of staff reporting most recent experience of harassment, bullying or abuse</td>
<td>44%</td>
<td>45%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

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

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

The staff survey in 2017 identified that some department’s results had declined and focused work was required to address these issues. There were plans to look at the top five and bottom five scoring areas to identify and share good practice. It was stated that the board were not surprised by the staff survey results and those areas that were in the bottom five scoring areas. However, it was unclear why they had not acted if they were aware of the areas that had issues.

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 (WRES).

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.

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, two questions showed a statistically significant difference in score between white and BME staff:

- **KF21**: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- **Q17b**: In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The trust’s People’s Plan for 2017-18, included clearly set out objectives relating to diversity, inclusion and race equality. Actions included reviewing current recruitment practices to ensure there were no hidden barriers, exploring how to attract staff from outside the local area and ensuring managers were as flexible as possible and equipped to support staff with particular requirements.

The trust did not have established Black and Minority Ethnic (BME) or lesbian, gay, bi-sexual, transgender (LGBT) network at the time of our inspection. A diversity network had been launched and included BME and LGBT. Only 12 staff were currently engaging in this network that met every six weeks. However, the trust were committed to developing the network and equality and diversity was now being addressed in a systematic way since the new director of people came into post. The results of the WRES and staff survey were being used to inform actions that had been taken and those that were planned. Work that had commenced on the equality and diversity agenda included, updating policies, holding a WRES workshop and introducing a specific email box that staff can submit queries to. At the time of our inspection it was too early to evaluate the impact of these recent action but frontline staff were aware of this work.

The senior managers we spoke with were not aware if there was an equality and diversity strategy, although one manager told that this needed to be developed. Staff we spoke with during our inspection were unclear who would be responsible for leading the development of this strategy.

Disciplinary data highlighted that concerns raised by staff from BME groups were more likely to result in the person they had made the allegation against being looked at under the disciplinary processes. While action had been taken to regularly review disciplinary conduct cases of BME and encourage early intervention and informal resolution, the issue of when BME staff raise a grievance against another member of staff still required further work to ensure a fair and just approach.
The chief medical officer had professional responsibility for 290 consultants and 150 non-career grade doctors. There were very few doctors reported to the GMC compared to other trusts and we were told that very few concerns relating to medical staff were addressed through the disciplinary process. Informal processes were reported to be the preferred course of action by the chief medical officer. This approach made other staff feel there was not a fair and just culture in the trust and not all staff groups were treated equally.

The trust were exploring a range of options to attract nursing staff to fill vacancies. They had recruited nursing staff from outside the UK and had recently recruited eight staff members from the Philippines who were being supported through a preceptorship programme. The trust had also piloted nurse apprenticeships and nurse associates as well as working with military for placements, to improve recruitment. They had also successfully supported some overseas nurses to pass their exam to practice as a qualified nurse in the UK who had faced challenges in passing their exams at other trusts.

**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.

From April 2017 to March 2018, the trust’s score was similar to the England average for recommending the trust as a place to receive care. In the latest period, March 2018, the recommendation rate at the trust was 96.3%, compared to 95.3% for the England average.

(Source: Friends and Family Test)

**Patient and relative feedback**

The inpatient survey for 2017 provided positive feedback about the care individuals received, with five areas scoring better than the national average. The trust were aware of the areas that they need to focus on to improve patient experience, these include providing better information on discharge and how to make a complaint.
We held a meeting with the trust’s governors which also included staff governors. They told us that they believed the trust culture was embedded at management level. During their safety walk arounds, they received consistent positive feedback from the patients and relatives about the standard of care they or their relative had received.

To support staff, meet the needs of patients with learning disabilities, the trust had one learning disability liaison nurse and one recently appointed associate practitioner employed across the services. Staff we spoke with were positive about this role and stated that they not only provided support and advice to the staff but also to patients which contributed to improving the patient’s experience.

The trust applied Duty of Candour (DoC) but it was acknowledged by the trust that this was an area that required more work to ensure all staff were clear of their role in relation to DoC and that the process was just and fair. The 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.

There was a DoC policy and an identified lead at Basingstoke Hospital and another who covered Winchester and Andover. It was reported that DoC was covered at the junior doctor’s induction and recorded on the trust’s electronic incident system when completed. Nursing staff stated that DoC was usually done by the medical staff and did not see that it could be done by others. Senior clinicians could provide examples of were DoC had been completed following incidents. To provide assurance that DoC was completed, each division had an identified lead who checked all patient response letters before they are sent to the patient or their family to ensure DoC had been covered appropriately and the letter responded to concerns raised.

**Sickness absence rates**

The trust’s sickness absence levels from February 2017 to January 2018 were consistently below the England average, although they followed a similar trend over the period.

![Graph showing sickness absence rates](image)

(Source: NHS Digital)

Staff side acknowledged that they were a relatively inexperienced group and were currently in discussions with the trust about their development needs. They all participated in an away day last year and their vision was to develop a group of people who could represent and support any member of staff irrespective of which union they belong to. All union representatives agreed that it
was difficult to secure the time to undertake their duties and challenging to identify time to support their members. Time was formally assigned to the role but their permanent roles were not back filled, this was stated to be due to a lack of clarity regarding who holds the budget for back filling these roles. There was a need to clarify funding arrangements to support staff to undertake their union duties if they are to do these effectively.

There was reported to be a lack of flexibility in releasing staff to undertake union duties. A union officer had to provide a week’s notice if they were supporting a member of staff and required time to undertake this duty. While union representatives acknowledged the need for this to ensure continuity in their departments, it was stated that this was not always possible to provide a week’s notice if they received an urgent request for support. The unions were exploring introducing a more formal arrangement such as all hearings taking place on a Friday to allow union representatives to diarise this day in advance and avoid staff having to attend without union support. They had also requested to attend specific meetings such as the matron’s meeting for agenda items that impact on staff so that they can assist staff prepare for any changes. To date this request has not been actioned. By inviting union representatives to specific meetings or for specific agenda items this would promote an open and supportive culture.

General Medical Council – National Training Scheme Survey

In the 2016 General Medical Council National Training Scheme Survey, the trust performed worse than expected in one area (feedback). Performance was the same as expected for all other indicators.

(Source: General Medical Council National Training Scheme Survey 2016)

Governance

Board assurance Framework

The trust provided their board assurance framework as of November 2017, which details the strategic objectives and accompanying risks. A summary of these is below:
If we do not maintain an appropriate skilled and engaged workforce, operating under one unified organisation-wide culture then this may lead to a failure to deliver our vision of a single service across multiple sites, poor care for our patients and dissatisfaction amongst staff.

If we do not have effective corporate and clinical governance structures then we will be unable to reassure ourselves of the quality of our services.

If we do not meet our regulatory and contractual responsibilities then this will impact on the quality of our services, our reputation and financial stability.

If we do not maintain good relationships with the local community then we may not remain their provider of choice for secondary healthcare.

If we do not deliver our strategic plan then this may result in an inability to maintain organisational stability.

If we do not have strong engagement in local system reforms then we may be unable to maintain the quality of clinical services.

If there is a disruption to trust core services due to a cyber-attack, major incident, fire or other untoward event then the trust will be unable to provide safe and effective care.

If we do not maintain and develop our major capital assets (estate, medical and non-medical equipment) then there may be unacceptable clinical, regulatory and financial consequences.

If we do not achieve our cost improvement and productivity plans then we will be unable to meet our financial challenges.

If we do not meet quarterly financial control total targets then the trust will lose sustainability and transformation funds (STF) (value £9.6M over year).

If we do not maintain and analyse accurate clinical information then we may be unable to maintain the quality of clinical services or reliable governance and reporting.

If we do not accelerate and embed the adoption of technology in the clinical and corporate areas then we will be unable to transform services.

If we do not improve the efficiency of our systems and processes then we will be unable to deliver excellent patient experience.
cost efficiency and our position as a competitive provider will be weakened.

(Source: Trust Board Assurance Framework – P112)

**Governance structure**

We reviewed the trust’s governance structure which was delivered through the divisional structure, led by the medical directors who have overall responsibility for their division and report directly to the CEO. The senior management team described the governance structures within each division and how this fed up to the central governance team and the board through their contribution to the monthly governance report prepared for the board.

These divisional leads, also hold full time consultants’ contracts alongside these additional governance roles. They have no identified time for these roles and worked flexibly to these arrangements. While this encouraged clinical input into these areas, it did not provide sufficient time for additional roles to be undertaken effectively. It was acknowledged by some directors that consultants undertaking these roles should have their clinical sessions reduced and specific management time assigned as at times they have cancelled clinical commitments. The job description for this role provided following our inspection stated that the balance of clinical practice and management and leadership responsibilities will be agreed with the director of the division.

However, we were told the chief medical officer was not supportive of providing designated management time within their job plans.

There was a central governance function led by chief medical officer who was the executive lead for quality and clinical governance. The associate director of governance was responsible for incidents, health and safety and links into the divisional health and safety groups and the trust’s risk committee. There were divisional governance partners based in each division who link to the central governance team via the monthly central governance meetings. The chief nurse attends SERG, CQSC and is the link with the CCG quality leads.

The trust board met regularly. Meetings were held in two parts, the first being in public, which started at 9.00 am, some staff expressed a wish to attend but stated that it was difficult due to work commitments. The board then met in private for part two. At the beginning of each board meeting there was a patient story, usually someone who had a positive experience of receiving care in the trust. We noted that the minutes of the board meeting were brief and did not include a summary of the discussions and challenges that had taken place. This meant that if clarity was required at a later date regarding a decision it may not be possible to provide this.

There was a range of committees and sub-committees however, the majority of these do not directly report to the board. The risk committee, chaired by a NED, was a formal subcommittee of the board, who were responsible for reviewing and assessing risk management processes and highlighting these to the board. The four divisions attended the risk committee rotating through one division per quarter and presented their high-level risks, anything rated 20 or above, by site with the top risks being escalated to the trust risk register. The trust risk register is reviewed quarterly at the risk committee. We noted that there was catastrophic (rated 25) risk on the risk register and the mitigations were not reducing the risk, it was unclear what additional action had been taken and if the mitigation had been reviewed to evaluate why it was not having the desired result. Following our inspection, we were told that all risks associated with capital funding were reviewed at every planning round and as part of financial reporting. These are also reviewed at the capital investment group, chaired by CN who has the ability with the chief financial officer to allocate capital funds in emergency cases. A report from the risk committee is linked to capital allocation and the divisional performance meeting, to ensure risk is considered at both these meetings.
The Clinical Quality and Safety Committee (CQSC) which was not a formal assurance and accountability committee or subcommittee of the board, was chaired by the chief medical officer and include two NEDs. We were told it was developed to facilitate medical involvement in quality. The committee was responsible for reviewing clinical safety and effectiveness and initiating learning and feedback to staff. It reports to the board through the governance report which is a standard item agenda.

The trust introduced a monthly Patient Safety, Effectiveness and Experience group (PSEEG), 12 months ago. This was chaired by the associate medical director responsible for governance with representation from the divisions. The aim of the group is to drive improvements in terms of patient safety; share learning from effective clinical outcomes and monitoring compliance and learning from patient’s experiences. The meeting’s topic rotated so one month the focus was patient safety, the next patient effectiveness, followed by patient experience with the aim to improve all three elements across the trust. This was not a board committee and therefore reported to the board via the governance report which was presented monthly. A deep dive into patient falls had been commenced by PSEEG to identify root causes. Specific wards had been identified to take part in this work, some with low rates of falls and others with high levels. It was anticipated that this work will identify good practice and areas for improvement that will be addressed to reduce the number of falls, however, we were not provided with a timescale for the completion of this work.

Staff we spoke with were unclear what the trust’s process was for receiving, reviewing and disseminating National Institute for Health and Care Excellence (NICE) guidance for implementation. The PSEEG had discussed this and the minutes stated the action that would be taken to follow up partial compliance with NICE guidance. It was also identified that evidence demonstrated that some NICE guidance that was initially reviewed and considered compliant with, was not the case and guidelines/policies did not fully reflect the NICE guidance, i.e. NICE falls guidance (2013). It was reported that this issue would be reviewed at the next PSEEG in August 2018.

Monthly serious events review groups (SERG) meetings took place, these were chaired by the associate medical director (governance). The meeting focused on reviewing all serious incidents and deciding which required investigation and undertaking cluster reviews of incidents which the central governance team pulled together. All serious incident investigations were led by a trained investigator supported by a member of the governance team and a specialist relevant to the incident. While we were told individuals leading investigations were trained in root cause analysis, it was unclear from the staff we asked who provided this training, the length of course and if they were expected to update this training at regular intervals. We were told that lead investigators could access investigation guides and standard templates on the intranet to assist them with their investigation. Learning post investigation was pulled together by a member of the governance team and shared with the divisions who cascaded this to their staff. The outcomes of cluster reviews were shared with the divisions, an example provided was learning from sepsis incidents to improve the sepsis pathway. An overview of serious incident investigations was presented in the public board with more details and discussions in part two, the private board. The minutes from this group demonstrated that there was membership from a range of professionals but a high number of apologies, demonstrating not all members of the group see this as a high priority to attend.

The annual clinical audit programme included national and local audits, this was developed in coordination with the PSEEG before being shared with the divisional governance groups for approval. There was a standard operating procedure that set out the framework for staff conducting clinical audits within the trust. This included the clinical audit registration form and a form that must be completed once the audit had concluded that provided a summary including any actions that will be taken. The trust had a ‘Practical guide to clinical audit’ that supported the clinical audit sessions that were run six a year and open to all professionals. Each audit had an identified lead and progress with completion of the audit was documented. At the PSEEG meeting in May 2018 the need for assurance that audits were being signed off in the divisions was discussed. The medical division had a process for signing off these at their divisional board and
the family division had started to have visibility but it is unclear what arrangements were in place to provide this assurance.

While the trust participate in a range of audits, during our inspection staff stated that clinical audit had very little impact on patient safety. For example, the sepsis pathway was improving the identification of sepsis patients but 40% of these patients did not receive antibiotics within an hour. To explore this in detail and drive forward improvements a new sepsis lead will be appointed, a task and finish group formed to develop the training on NEWS 2 which will be delivered via the divisions with a plan to implement this tool in October 2018. We were unable to assess the impact of these actions at the time of our inspection as they had not been completed.

Management of risk, issues and performance

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>353.8m</td>
<td>385.4m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(6.9m)</td>
<td>4.7m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>360.7m</td>
<td>380.7m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>5.1m</td>
<td>6.4m</td>
</tr>
</tbody>
</table>

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

- The Chief Finance Officer was appointed in May 2016 and leads on finance, procurement, business intelligence and IM&T.
- The board committee structure has both an audit committee and a risk committee with clear terms of reference. Both are chaired by appropriately qualified non-executive directors – the chair of the audit committee is a qualified accountant.
- The trust’s financial position is reviewed at the executive committee and the board.
- The financial information received by the board includes a balance of board and divisional level and covers both actual and future-looking projections.
- Financial performance is reviewed and challenged at the executive committee.

(Source: NHSI Finance assessment June 2018)

Management of risk, issues and performance

There was an audit committee chaired by a NED, whose focus was assessing internal controls and financial rigour. The trust did not have a finance committee and used the board of directors for management and scrutiny. All directors were fully involved in financial decisions and finance systems go through audits. The NEDs had adequate financial expertise and described a shared understanding of the financial position of the trust and areas of development. The trust were working on areas of high costs such as agency staffing usage and reducing inefficiencies with quality improvement initiatives driving some areas of financial savings. The chief finance officer sufficiently prioritised quality care when considering cost reduction initiatives and worked closely with the chief nurse to ensure any cost savings did not negatively impact on patient care. The trust had not been able to meet their agency caps for the last two years, resulting in additional financial challenges.
The trust had clear processes in place to manage risks, issues and performance. The trust's risk management structure and approach to managing its risks was set out within a single document, the Risk Management Framework. This document stated staff responsibilities for risk management, risk assessment and scoring, use of the risk register, and strategy implementation. The board were clear about their key risks which included estates and equipment but it was reported that the lack of access to capital funds was restricting their ability to address these risks effectively.

The estate management team confirmed that the main risks for the estate were asbestos and CCTV access for security of the building, with the emergency department (ED) and the acute assessment unit (AAU) being identified as high-risk areas. A risk management paper covering these areas had been drafted and submitted to the board. Six monthly reviews of asbestos in the estate were undertaken by the seven trained staff members. Reports from these reviews were shared with the board. There was a maintenance backlog, which included the replacement of 94 sets of doors to ensure they were compliant with fire regulations. We were told to complete all the work in the backlog this would require capital expenditure of around £70 million. Due to the financial challenges the trust faced this meant that it would not be possible to clear this backlog in the near future.

The trust had an incident reporting system, it was reported that this included providing feedback to staff through a range of methods including “Learning Points” bulletins, via the ‘Midweek Message’ and governance newsletter “Quality Matters”. The CEO also shared learning in the monthly “In Touch” and open sessions. Most staff we spoke with were aware of how to report an incident but stated they did not always receive feedback and therefore did not see the value of reporting as they did not see changes or action taking place. While other staff reported that they would not report incidents because they felt there was a ‘blame culture’ in the trust and they feared the repercussion if they reported an incident.

Like many other NHS trusts the trust stated it was difficult to achieve both financial and performance targets. All projects including cost improvement projects (CIPs) had a quality impact assessment (QIA) completed and signed off by a director. At executive level discussions took place to review projects and CIPs against risks. For example, the equipment replacement programme and how this could be achieved with need for the trust to save money. It was reported that the chief medical officer was supporting this project and it would be achieved though staggered spending with essential equipment only being replaced. It was stated this approach had been communicated to staff but many staff we spoke with were unaware of this. Any risks of not delivering CIPs were identified during monthly monitoring meetings and the mitigation recorded. If a CIP scheme cannot be delivered, the team were supported to explore alternative schemes to achieve the CIP.

Divisional performance was reviewed monthly. It was reported that there was a need to increase productivity in the trust as while surgery was increasing, theatre utilisation was only 72% at Winchester and Basingstoke, and 50% at Andover. There was also a need to focus on the high cost work but a lack of critical care capacity was impacting on the trust’s ability to undertake all these cases and some work was being undertaken at a local private hospital. The trust had approved plans to increase its critical care capacity by two beds but were unable to confirm when these additional beds would be operational.

It was reported that there were gaps in staff knowledge in relation to Mental Capacity Act (MCA), Deprivation of Liberty (DOLS) and do not attempt cardiac pulmonary resuscitation (DNACPR). To address this, work including providing training was being undertaken but the divisions were aware that this posed a risk to patients.

Recruitment and retention of staff in some areas and in some staff groups was reported to be an issue and a risk to service delivery. At the time of inspection there was a nurse vacancy rate of 28% and turnover of 10%. The trust was aware of those areas with the highest vacancy rates, these include acute wards, emergency department (ED) at Basingstoke and Winchester, orthopaedics and stroke at Winchester. To ensure appropriate staffing levels agency staff were
used. The trust had recognised the long-term risks of insufficient qualified nurses and were exploring how this could be addressed. Initial work completed by the trust identified some of the root causes, these included the length of time it takes to complete the recruitment process, matron’s lack of capacity to shortlist applications, a lack of a clear strategy on how agency usage will be managed with a target of zero usage by September 2018, lack of exit interviews and lack of learning about the reasons for poor retention. Work had commenced to address these issues this included introducing a new process for exit interviews and a patient governor had been included in the chief nurse recruitment.

There were also significant medical staffing issues in the ED due to the lack of middle grade doctors as a result of the RHCH site not receiving deanery training posts. A business plan had been agreed to recruit six consultants for ED. Although staff told us that the concerns remain that this would not provide 24-hour consultant presence in ED to support the junior doctors.

We were told that the trust did not have a workforce committee although HR staff were keen to set up one up with appropriate membership to share learning and work with a range of professionals to address recruitment and retention issues. There was an identified recruitment action plan for the next 12 months that included running a campaign such as open day in Winchester in May 2018 and Basingstoke in July 2018 and enlisting the service of a recruitment company and social media including Twitter. Retention initiatives included career conversations, streamlining the appointment process for internal promotions and moving staff between departments to share skills and knowledge.

Monthly workforce reports were submitted to the board and included agency usage and vacancies. These reports showed that the trust had not managed to reduce the numbers of agency staff used, but was increasing agency usage. All areas have been tasked to have zero agency usage by September/October 2018. It was unclear how this will be achieved but staff were clear that high cost agency staff would only be used when all other options had been exhausted.

There was an associate director responsible for professional development for nurses who also led on liaison with the universities for student nurses. The trust achieved training provider status for apprentices in April 2018, which will enable health support workers to complete training and have a career pathway for example via the associate nursing pathway. It is anticipated that this will contribute to nurse recruitment in the trust.

The chief pharmacist led the pharmacy department and the department is part of the Family and Clinical Support Division. The department prepared and shared quarterly divisional reports on medicines trends in their areas/departments for each of the three divisions. An annual medicines optimisation report is presented at the trust board. There is an annual pharmacy plan that included three strategic priorities that link to the trust’s strategic framework.

Staff vacancies and the pharmacy department environment on the Winchester site were reported to be the pharmacy services main risks. Staff vacancies and a number of staff on maternity leave across the sites had resulted in a lack of clinical pharmacy input for some wards. Cover was reviewed and reprioritised daily to make sure that patients with the greatest medicines risk were reviewed. However, at our core service inspection we found that this reprioritised meant that areas perceived as low risk had no pharmacy input for significant periods of time. The poor fabric of the pharmacy on the Winchester site made working conditions for the team based there challenging. There was a workforce strategy in place and plans for a new pharmacy department at the Winchester site, a decision on if this development was approved is expected in September 2018.
Trust corporate risk register

As of February 2018, there were 45 risks logged on the trust risk register. The risks are broken down by the following business units:

<table>
<thead>
<tr>
<th>Trust Area</th>
<th>No. of Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate services</td>
<td>16</td>
</tr>
<tr>
<td>Family and clinical support</td>
<td>12</td>
</tr>
<tr>
<td>Medicine</td>
<td>9</td>
</tr>
<tr>
<td>Directors</td>
<td>5</td>
</tr>
<tr>
<td>Surgery</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>

Of the 16 corporate services’ business unit risks there are nine with a target risk identified and seven with no target risk. These 16 corporate services risks are listed below:

<table>
<thead>
<tr>
<th>ID</th>
<th>Business Unit</th>
<th>Description</th>
<th>Gross risk exposure</th>
<th>Net risk exposure</th>
<th>Target risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1082</td>
<td>Communications</td>
<td>If the intranet website continues to be an unsupported version of SharePoint, any technical issues will potentially lead to the loss of service and be unrecoverable.</td>
<td>20</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>1409</td>
<td>Estates</td>
<td>If the condition of the drainage system under the hospital is not known then there is a risk of blockages or pipe failure resulting in sewerage leaks.</td>
<td>20</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>1081</td>
<td>Communications</td>
<td>If the external website is on an unsupported platform following the withdrawal of vendors support then no development or remedial action can be taken and could render our website content inaccessible to the public.</td>
<td>12</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>1447</td>
<td>IT Services</td>
<td>If there is insufficient funding for licencing, then the Trust will not be legally licenced to use software, or would be using unsupported software which could result in a financial penalties or an increased risk of a cyber attack.</td>
<td>16</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>1446</td>
<td>IT Services</td>
<td>If we do not have sufficient capital programme to replace aging hardware then it may result in a degraded service.</td>
<td>16</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>1411</td>
<td>IT Services</td>
<td>(IG toolkit, IG training, preparations for the implementation of the GDPR) then we are at risk of breaching</td>
<td>16</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>ID</td>
<td>Department</td>
<td>Description</td>
<td>Score</td>
<td>Rating</td>
<td>Target</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>1489</td>
<td>Estates</td>
<td>If leaking roofs are not repaired then there is a risk of further structural damage and internal environmental impacts.</td>
<td>20</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>509</td>
<td>Facilities</td>
<td>If the main security control systems fail then the guarding of critical areas and locked down clinical areas would be at risk. If the kitchen flooring in BNHH is not replaced, then there will be an increase in slips, trips and falls which can result in injury to staff and legal claims against the trust.</td>
<td>15</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>445</td>
<td>Performance &amp; Contracting</td>
<td>If we are unable to respond and refute CCG challenges on activity and data submissions then payment may be withheld, leading to financial losses for the trust. If the trust is significantly off financial plan, NHSI may move straight to opening an investigation to assess whether the trust could be in breach of its licence. If the C&amp;B interface service that is linked to PAS, which is accommodated in the CSC Data Centre at Kent, is not upgraded there is a likelihood that the service will fail at some point, due to aging hardware then it would be difficult to provide administrative services. If there was a significant IT failure, then the recovery time could take potentially weeks to resolve, as there is insufficient /robust Disaster Recovery plans in place. If systems are not updated with Microsoft Security patches then there is a risk of a cyber security attack. If the current level of IT noncompliance identified continues (20 elements) then the Trust is exposed to an increased risk of IT security breaches. If there are insufficient processes in place for managing permissions then there is a risk of unauthorised user access (e.g. shared drives) and an increased risk of data corruption by cyber-attacks.</td>
<td>20</td>
<td>16</td>
<td>No target</td>
</tr>
<tr>
<td>1089</td>
<td>Finance</td>
<td></td>
<td>16</td>
<td>16</td>
<td>No target</td>
</tr>
<tr>
<td>1329</td>
<td>IT Services</td>
<td>If there are insufficient processes in place for managing permissions then there is a risk of unauthorised user access (e.g. shared drives) and an increased risk of data corruption by cyber-attacks.</td>
<td>16</td>
<td>16</td>
<td>No target</td>
</tr>
<tr>
<td>1350</td>
<td>IT Services</td>
<td>If there was a significant IT failure, then the recovery time could take potentially weeks to resolve, as there is insufficient /robust Disaster Recovery plans in place. If systems are not updated with Microsoft Security patches then there is a risk of a cyber security attack. If the current level of IT noncompliance identified continues (20 elements) then the Trust is exposed to an increased risk of IT security breaches.</td>
<td>15</td>
<td>15</td>
<td>No target</td>
</tr>
<tr>
<td>1351</td>
<td>IT Services</td>
<td>If the current level of IT noncompliance identified continues (20 elements) then the Trust is exposed to an increased risk of IT security breaches. If there are insufficient processes in place for managing permissions then there is a risk of unauthorised user access (e.g. shared drives) and an increased risk of data corruption by cyber-attacks.</td>
<td>15</td>
<td>15</td>
<td>No target</td>
</tr>
<tr>
<td>1352</td>
<td>IT Services</td>
<td>If the current level of IT noncompliance identified continues (20 elements) then the Trust is exposed to an increased risk of IT security breaches. If there are insufficient processes in place for managing permissions then there is a risk of unauthorised user access (e.g. shared drives) and an increased risk of data corruption by cyber-attacks.</td>
<td>15</td>
<td>15</td>
<td>No target</td>
</tr>
<tr>
<td>1359</td>
<td>IT Services</td>
<td>If there are insufficient processes in place for managing permissions then there is a risk of unauthorised user access (e.g. shared drives) and an increased risk of data corruption by cyber-attacks.</td>
<td>15</td>
<td>15</td>
<td>No target</td>
</tr>
</tbody>
</table>
The trust had a board assurance framework (BAF) in place and key risks identified including the ED staffing, lack of capital for updating the estate and equipment and risk that the financial targets may not be met. The BAF was discussed at the risk committee and with executives at the start of the financial year and reviewed quarterly at the board. The trust’s internal auditors reviewed the BAF annually, this included recommendations to the board to improve the BAF.

The risk committee was chaired by a NED with membership of the CEO, chief medical officer and chair and representatives including the chief finance officer and the chair of the audit committee. The committee meets quarterly and divisional representatives attend annually to present their risk register. The risk committee reviewed the trust’s risk register and BAF including mitigation at each meeting. On a quarterly basis the committee provide a high-level risk register and verbal update to the private part of the board.

Each division had a risk register which is presented to the risk committee on a rotational basis, with each register reviewed annually by the committee. Business unit risks are reviewed by the divisional management team at the monthly performance meetings, and divisional health and safety risks are scrutinised at the trust’s health and safety committee. Any member of staff can add a risk to the divisional register, these are all reviewed by the manager and divisional lead to ensure they are risks and not issues and that mitigating actions have been documented and the risk rating is appropriate.

**Information management**

The trust provided appropriate information to support staff to review, challenge and act on their performance. Business intelligence could produce daily, weekly and monthly activity reports that were used to improve flow through the trust. For example, information on the reason for delayed discharges was used in discussions with partners to ensure action was taken.

The divisional management teams had access to a range of information to support them in their management role, this included monthly performance dashboards. The three divisions all had a consistent approach to performance management. This included measuring performance against agreed key performance indicators (KPIs), using a balance score cards that included a range of areas that were monitored including activity, workforce, quality, KPIs such as complaints, structured judgement review (SIRI) and falls. The data was discussed on the weekly ‘comms calls’ at divisional level that all wards/services in the division were required to attend. The monthly divisional performance review meetings were chaired by the chief operating officer and attended by a range of professionals, during which the data was reviewed and appropriate challenge provided. Following these meetings divisional performance reports were presented to the board, in the monthly governance report to provide an overview of performance.

The clinical staff had led the development of an in-house clinical record. This was reported to facilitate effective sharing information with other professionals to ensure consistent timely information was available to provide safe, effective care.

While a range of reports were prepared which fed into the governance report and other board reports staff we spoke with stated that the quality of the reports produced needed to be improved. This improvement included more analysis of data to explain spikes and changes. There was also a need to clarify which reports were presented at other committees and groups to facilitate sharing of information.

The CEO had board responsibility for information risk and were supported by the Caldicott guardian. The information governance manager was responsible for the co-ordination and monitoring of progress against the Information Governance Toolkit and the action plan. The Information Governance (IG) Toolkit is a self-assessment audit completed annually by every NHS Trust and submitted to NHS Digital. The purpose of the IG Toolkit is to provide assurance of an
organisation’s information governance practices through the provision of evidence of around 45 individual requirements. The self-assessment must be submitted to NHS Digital, with all evidence uploaded by 31 March 2018. The trust's Information Governance Assessment Report overall score for 2017/18 was 71% and was graded as “Satisfactory”. However, during our inspection we were informed that the IG training figures submitted by the trust were incorrect and lower than reported, which would impact on compliance with the toolkit.

Responsibility for information governance was transferred to the information technology (IT) team in January 2018 of which the information governance manager is a member and is accountable to the chief finance officer and SIRO. It was reported the team faced recruitment challenges with a need to recruit the data protection training officer post, a new post. Following our inspection, the trust stated they had recruited to this post and the individual was due to commence in post in July 2018.

The Caldicott Guardian, a consultant haematologist, was also the chief clinical information officer, they had been in post since October 2017. To prepare for the role they attended the annual IGA training conference, shadowed the previous Caldicott Guardian and worked closely with the Southampton Hospital guardian. The board received regular updates from the chief medical director who was the executive lead for Caldicott.

There was a General Data Protection Regulation (GDPR) steering board, it was stated that the role of this board was becoming more demanding since the new legislation had come into effect. Risks to data security were identified through the risk management processes at departmental and divisional level as well as trust wide through the role of Caldicott Guardian and the information governance manager. Incidents and near misses in relation to data security were reviewed by the information governance manager and Serious Incidents Requiring Investigation (SIRIs) were reviewed at the SERG. Incidents were reported to the executives and board in the governance paper. Two incidents had been reported to the Information Commissioner’s Office (ICO) in 2017/18. No further action was required. One ICO notification for breach of the Data Protection Act was received, this related to a failure to satisfy a subject access request submitted on the 27 June 2017. HHFT responded to ICO with the actions taken on 24 January 2018.

The Information Governance Training Strategy identified how staff would be assisted to understand information governance. It was reported this training was provided both via e-learning and bespoke face to face training. Attendance at this training is monitoring through the divisional performance reviews and reported to the board.

The trust submitted notifications to the Care Quality Commission in the past year in line with their statutory responsibilities. The commission received notifications about never events that occurred and safeguarding.

Engagement

- The Trust works closely with partner organisations within the Hampshire and Isle of Wight STP and local delivery systems.

(Source: NHSI Finance assessment June 2018)

It was reported that engaging with the local community could be challenging. To address this the trust had met with hard to reach groups such as travellers, holding focus groups to look at specific service. They had engaged with specific groups through the youth council, carers café, maternity service liaison committee and cancer services partnership. This approach allowed the trust to collect the views of local people using the service to inform developments. To encourage on-going engagement the trust, went into the community to update them on the progress of developments.
The trust used a range of approaches to collect patients’ views including the Friends and Family Test (FFT) results, complaints, complements, surveys to obtain feedback and identify areas for improvement. The trust commissioned an external company in May 2017 to conduct a programme of independent research and engagement, with local people, including hard to reach or seldom heard groups regarding the possible outcomes of changes to acute services. We were not provided with evidence of how these views had been used or would be used to inform service development. The governors have also involved patients in recruitment and involved them in PLACE visits.

The trust had a patients’ voice forum which met regularly with key members of staff to exchange information and discuss concerns. Members of this group visited wards and departments and carried out assessments of the care environment and participated in staff recruitment. This approach provided the trust with an external view of the quality of the care environment.

The trust used a range of approaches to engage with staff these included ‘In Touch’ sessions that are broadcast live on the staff Facebook page. The trust’s AGM is also streamed live and available on YouTube. The CEO regularly attends the junior doctor’s induction and encourages them to share ideas for improvements with her during their time at the trust.

The structured judgement review (SJR) process in learning from deaths captured feedback to relatives and if they are unhappy with the outcome. These views were recorded using the internal incident reporting process and sent to the complaints team and fed back into governance meetings. The bereavement team also liaised with families and gave staff details of issues that families had experienced when their relative had died which the complaint’s team followed up.

The dementia team had links with various community organisations such as Age concern, carers café, Alzheimer’s society, Andover MIND to support people on discharge from hospital. This enabled the team to direct families to organisations outside the trust for support and information. The trust used a range of approaches to engage with its staff and stakeholders, these included regular publications such as ‘InTouch’, open forums and ward visits with the aim to facilitate involving staff in decisions about the future of service developments and assist in sharing learning. However, some staff reported that they felt they had no ability to participate in decisions that impacted on them and felt that they had to just get on with the day job. While the trust are providing these opportunities for staff to contribute there is a need to explore how they engage with staff groups unable to attend these open forums due to work commitments.

Concerns were raised by several staff members about the support of staff at the Andover site specifically around how the potential changes to provision of the MIU were communicated. It was reported that staff received a text or direct message informing them of changes to their working hours and that they would be expected to make up their hours on Kingfisher ward due to the reduced opening hours of MIU. This resulted in confusion and staff not feeling valued. However, some senior staff did state that a senior manager had visited the MIU on the day the changes were announced and spoke with the staff on duty. While this approach supported those on duty, it only captured some of the team, there is a need to evaluate when the use of text messages is not appropriate and consider alternatives.

The trust sought the views of the unions on its policies and procedures but they were not a member of the policy group. It was stated that there was not always enough time, usually only a week, to provide comments. To ensure that staff side can provide appropriate comments on policies there is a need to review the time allocated.

The board participated with the local health economy to drive improvement. The CEO is the convenor of the local Care System group which aims to increase the co-ordination of care and has a quality governance sub group. Four times a year the trust meets formally with their partners to explore joint working, projects to date these have included work that has resulted in reducing the length of stay. To address delayed discharges for end of life patients the trust introduced a rapid discharge process and commissioned care home assessments to ensure there is minimal delay for these patients.
The pharmacy leadership team engage with internal stakeholders such as clinical matrons and external stakeholders such as neighbouring NHS Trusts and the CCG prescribers’ forum. This promoted sharing of knowledge, learning and opportunities for benchmarking performance.

**Learning, continuous improvement and innovation**

**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>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 days</td>
<td>96%</td>
</tr>
<tr>
<td>What is your target for completing a complaint?</td>
<td>25 working days</td>
<td>65% (March 2017 - February 2018)</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>Target agreed with complainant on an individual basis</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,082 (March 2017 - February 2018)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

**Number of complaints made to the trust**

The trust received 561 complaints from March 2017 to February 2018, taking an average of 29.5 days to resolve them; 178 of these complaints (31.7%) were about clinical treatment and 107 complaints (19.1%) were about communication.

The outpatients core service received the most complaints with 151 (26.9%); with a prevalent theme of clinical treatment with 68 complaints (45.0%), followed by communication with 34 complaints (22.5%). Medical care had the second highest number of complaints with 110 (19.6%), of which 30 (17.3%) were about patient care.

The table below shows a breakdown of complaints by core service:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
<th>Average time to resolve (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>151</td>
<td>26.9%</td>
<td>27.6</td>
</tr>
<tr>
<td>Medical care</td>
<td>110</td>
<td>19.7%</td>
<td>31.3</td>
</tr>
<tr>
<td>Surgery</td>
<td>99</td>
<td>17.7%</td>
<td>33.9</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>88</td>
<td>15.7%</td>
<td>25.0</td>
</tr>
<tr>
<td>Maternity</td>
<td>27</td>
<td>4.7%</td>
<td>29.9</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>4.7%</td>
<td>31.0</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>22</td>
<td>3.9%</td>
<td>31.0</td>
</tr>
<tr>
<td>Children and young people</td>
<td>21</td>
<td>3.7%</td>
<td>32.6</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>12</td>
<td>2.2%</td>
<td>22.7</td>
</tr>
<tr>
<td>End of life care</td>
<td>3</td>
<td>0.5%</td>
<td>25.0</td>
</tr>
<tr>
<td>Critical care</td>
<td>2</td>
<td>0.4%</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>561</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>29.5</strong></td>
</tr>
</tbody>
</table>
The table below shows a breakdown of complaints by subject type:

<table>
<thead>
<tr>
<th>Subject type</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
<th>Average of time taken to complete if closed (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>178</td>
<td>31.8%</td>
<td>31.2</td>
</tr>
<tr>
<td>Communication</td>
<td>107</td>
<td>18.9%</td>
<td>32.4</td>
</tr>
<tr>
<td>Patient Care</td>
<td>84</td>
<td>14.9%</td>
<td>30.9</td>
</tr>
<tr>
<td>Admissions and Discharges</td>
<td>46</td>
<td>8.3%</td>
<td>27.9</td>
</tr>
<tr>
<td>Values and Behaviour</td>
<td>46</td>
<td>8.2%</td>
<td>21.9</td>
</tr>
<tr>
<td>Appointments</td>
<td>37</td>
<td>6.6%</td>
<td>22.4</td>
</tr>
<tr>
<td>Trust Admin/Policies/Procedures</td>
<td>16</td>
<td>2.9%</td>
<td>27.5</td>
</tr>
<tr>
<td>Facilities</td>
<td>9</td>
<td>1.6%</td>
<td>25.5</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>7</td>
<td>1.3%</td>
<td>24.8</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>7</td>
<td>1.3%</td>
<td>19.8</td>
</tr>
<tr>
<td>Access to Treatment and Drugs</td>
<td>7</td>
<td>1.2%</td>
<td>28.8</td>
</tr>
<tr>
<td>PDW</td>
<td>5</td>
<td>0.9%</td>
<td>28.0</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0.9%</td>
<td>60.5</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4</td>
<td>0.7%</td>
<td>32.5</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>0.2%</td>
<td>51.0</td>
</tr>
<tr>
<td>Staff Numbers</td>
<td>1</td>
<td>0.2%</td>
<td>9.0</td>
</tr>
<tr>
<td>Commissioning</td>
<td>1</td>
<td>0.2%</td>
<td>14.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>561</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>29.5</strong></td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From March 2017 to February 2018, the trust received 345 compliments.

A breakdown of compliments by core service is in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Total number of compliments</th>
<th>Percentage of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>88</td>
<td>25.5%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>84</td>
<td>24.3%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>83</td>
<td>24.1%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>24</td>
<td>7.0%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>22</td>
<td>6.4%</td>
</tr>
<tr>
<td>Maternity</td>
<td>20</td>
<td>5.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>7</td>
<td>2.0%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>7</td>
<td>2.0%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>5</td>
<td>1.4%</td>
</tr>
<tr>
<td>Critical care</td>
<td>4</td>
<td>1.2%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>345</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The surgery core service had the highest number of compliments with 88 (25.5%), followed by medical care with 84 (24.3%) of the total compliments.
In 2017/18 the trust had 3197 nominations for their WoW awarded. Any member of staff or patient can nominate a staff member who they think has gone the extra mile to provide outstanding customer care. These awards were presented by an executive and staff who have received these awards reported they felt proud to have been recognised.

Complaints

There was a clear process for the management of complaints. Complaints are investigated and reviewed at divisional level to ensure all points raised are covered and an appropriate response. The CEO reviewed all complaint responses and delegates responsibility to an executive in her absence. Targets were in place to acknowledge and respond to complaints. The trust was not currently meeting the response timeframe target, 65% of complaints were responded to within 25 days, with the average length of time for complainants to receive a response being 30.4 days.

We reviewed five complaints records and these confirmed the trust was meeting the statutory requirements of “The local Authority Social Services and National Health Services Complaints (England) Regulations (2009). The Management and Handling of Complaints reflected the recommendations from The Francis Report (2013). In doing so, the trust was also working to both the spirit and intent of the “Good Practice Standards for NHS Complaints Handling (September 2013) outlined by the Patients Association.

During 2017/18 the Parliamentary and Health Service Ombudsman (PHSO) closed a total of six complaints they investigated in relation to the trust. Of these, four complaints were not upheld and two complaints were partly upheld. Five new referrals relating to care provided by the trust were received by the Ombudsman in 2017/18 representing 1% of the total number of formal complaints received. Of these, one of the new referrals was closed in year and not upheld following investigation. Four complaints remain open to the PHSO at the end of 2017/18.

The trust had a clear process for reviewing deaths that occurred at the hospital. There was a learning from death’s policy which in line with the national guidance was published in 2017. The policy included DoC; however, this refers to informing the patient and not the relative of the deceased. While the policy refers to submitting a quarterly learning from deaths report to the public board as outlined in the national guidance on Learning from Deaths, there was no evidence that this action had been completed.

There was a lead consultant responsible for learning from deaths and a mortality team, with a NED linked to the group. The trust policy stated that all avoidable in-patient deaths that occurred at the hospital were reviewed. The mortality surveillance group, a multi-disciplinary and multi-professional group were responsible for undertaking the initial reviews and had started feedbacking to divisions using the new tool. Any death of patients diagnosed with a learning disability, serious mental health diagnosis, death following elective surgery and a proportion of randomly selected patients were reviewed by one of the 25 doctors who were responsible for undertaking in depth reviews of deaths using the structured judgement review (SJR) process. To date 1160 deaths have been reviewed with 83 of these deaths being referred for a SJR. There was some assurance that learning disability, mental health and elective surgery patients were triggered in the SJR process although the flagging system to identify these patients was reported to be currently unreliable and therefore some cases may be missed.

The benefit of this approach had meant that a wider range of professionals were involved in the group. A review of recent patient deaths we looked at all included an initial review and if necessary referral back to specific teams for investigation where appropriate. Mortality reviews provided a structured way of identifying quality gaps in care and learning from deaths is identified through the mortality surveillance group and shared with the divisions through PSEEG. We were told that these reviews had resulted in two serious incidents being identified and reported.
The trust’s balanced score card provided data on death reviews. For March 2018, it showed that the number of adult deaths reviewed was significantly lower but the number of deaths had not reduced by the same rate. It is unclear why this was the case, we were told the mortality team were aware of this fact. We were not provided with any evidence of the actions taken to investigate this drop-in death reviews. Following our inspection, the trust stated that the executive committee had discussed the drop-in mortality reviews and agreed a plan to increase the number of mortality reviews. However, this action plan was not provided during or following the inspection.

There was identified safeguarding leadership in the trust, the CN was the executive lead for safeguarding. We found the trust wide safeguarding leads to be well informed regarding national safeguarding initiatives and there were clear links to the trust board. Information we reviewed and our discussions with safeguarding leads for adults and children indicated there was evidence of good practice in this area of risk. This included joint working between the trust and external agencies to achieve positive outcomes for patients. The trust had a named nurse, midwife and doctor for safeguarding, this meant there was appropriate staff responsible for providing safeguarding leadership in the trust.

**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>Joint Advisor Group on Endoscopy (JAG)</td>
<td>Basingstoke and North Hampshire Hospital – January 2014 Andover War Memorial Hospital – March 2015</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>Mortuaries hold current Human Tissue Authority (HTA) licences</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation (CPA) and its successor Medical Laboratories ISO 15189</td>
<td>Cellular Pathology – ISO offer made, awaiting final confirmation (hold CPA accreditation). All Blood Sciences laboratories across Hampshire Hospitals NHS Foundation Trust are accredited by UKAS to ISO standard 15189 (2012). ISO offer made, awaiting final confirmation (hold CPA accreditation).</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>The service does not have CHKS accreditation but it does have ISO Quality Management Certificate ISO 9001:2008</td>
</tr>
</tbody>
</table>

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

**Quality improvement**

The trust had a quality improvement (QI) strategy dated 2018-20, that identified the principles for QI, there was no trust wide methodology that all projects used. A quality improvement academy had been launched in the last few months aiming at developing the improvement capability of staff at the trust. There were QI champions to support the QI programme and the trust had introduced a three tier HHFT QI training programme that staff compete over a six month period and took 18 hours. The first group of 16 staff had completed this training, the second cohort of 20 staff were
due to start the training during our inspection. We were told the new intake of junior doctors would be completing half a day learning in QI methodology and would be expected to undertake QI work throughout the year supported by the transformation team.

Staff were encouraged to put forward ideas for improvements. The QI team told us that they had 126 registered projects, of these 50 were active and 45 were currently being reviewed. It was unclear what stage the other 31 projects were at. The QI programme is not aligned with the audit programme to ensure QI projects were audited for effectiveness and audit outcomes identify potential QI projects. This had been acknowledged and there were plans to hold a trust wide audit and QI study day in November 2018.

The trust had a range of research projects on going which were generating a significant income for the trust from external funding. Research findings were shared with staff via a range of methods including at the annual general meeting, patient events and at lunchtime research sessions. The board received quarterly reports on the research programme with an annual presentation. The team were committed to using the research results to improve patient care and ensuring there was appropriate governance surrounding all projects and taking action if staff fail to comply. An example was provided of a nurse who breached the team’s governance arrangements regarding obtaining consent. Action was taken to address this breach.

The trust had an aging population with a high number of frail patients that often experience delayed discharges due to a lack of residential care and community support that would enable them to return to the community. The trust had taken steps to ensure these patients received care in the most appropriate care setting and have commissioned residential care beds. This resulted in addressing some but not all delayed discharges and facilitated patients receiving care in the most appropriate care setting.

The chief registrar spends 50% of their time focusing on medical workforce, quality improvement, leadership and projects. The remainder of their time is spent working clinically. To date the post holder had rolled out ‘Hospital at night’ in Basingstoke, which is recommended by the GMC to provide adequate support for junior doctors overnight. The scheme is supported by a new consultant for out of hours care and has received positive feedback from junior doctors. We were not provided with any evidence that this scheme would be implemented at the other two sites. Following our inspection the trust stated that the scheme would not be rolled out at Andover but was being implemented at the Winchester location.

The post holder had also started the doctors’ forum which has been very successful. Most issues discussed at this meeting related to medical staffing problems and equipment issues. This forum was stated to be an effective forum at which discussions resulted in resolution of issues or identification of possible solutions. It was stated that the CEO had attended this forum to provide the junior doctors with an opportunity to raise any concerns with her.

The trust’s dementia team based in ED consisted of a speciality doctor, a band 6 and a band 7 nurse, four therapy practitioners and three in reach workers linked with the community team. The team offered advice and support to patients, staff and relatives at all three sites. They were responsible for the assessment and screening using the geriatric assessment (CGA) tool, of any patient over 75 years of age admitted to ED who met the frail safe criteria. They had links with the consultant nurse in the community as part of admission avoidance strategy and supported patients to be seen and discharged to be cared for in their own home. Staff reported that this had a positive impact on admission avoidance.

The stroke unit had developed individual folders which were available at patients’ bedsides and contained detailed information about the types of stroke, their treatment to support patients and relatives understanding their condition.
Urgent and emergency care

Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

At Royal Hampshire County Hospital (RHCH) the trust delivers front door services in the emergency department, and has 28 in-patient medical assessment beds and 10 high care in-patient beds. Andover War Memorial Hospital (AWMH) has a minor injuries unit (MIU).

There are six assessment trolleys and six chairs for medical assessment of the acute take, ambulatory emergency care (AEC) and GP referrals. There is also provision of a rapid access clinic and medical assessment for ambulatory medical patients.

(Source: Routine Provider Information Request – Context Acute)

Basingstoke and North Hampshire Hospital (unscheduled care) provides an emergency medicine service through a Type 1 Emergency Department (ED) including trauma & cardiology. There is a minor injuries service provided by the emergency nurse practitioner service.

(Source: Routine Provider Information Request – Context Acute)

The department has:

- 12 majors cubicles (including side rooms)
- Four bedded resuscitation room where both adults and children are seen.
- 7 bed short stay ward

Medical patients who are referred by their GP are admitted directly to the acute admission unit adjacent to the ED. We did not inspect the AAU as part of this inspection however, it was considered within the Medicine core service inspection.

We have previously inspected this core service using our revised inspection methodology, once before in July 2015. We rated the service good overall.
Activity and patient throughput

Total number of urgent and emergency care attendances at Hampshire Hospitals NHS Foundation Trust compared to all acute trusts in England.

There were 124,302 attendances from February 2017 to January 2018 at Hampshire Hospitals NHS Foundation 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 increased from 2016/17 to 2017/18. In 2017/18, rates were higher than the England average.

(Source: NHS England)
Urgent and Emergency Care attendances by disposal method, February 2017 to January 2018

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment
(Source: Hospital Episode Statistics)

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

Mandatory training completion rates

The trust set a target of 80% for completion of mandatory training, with the exception of the information governance module, which had a target of 95%. Furthermore, the trust did not provide targets for immediate life support and medicine management training modules.

A breakdown of compliance for mandatory courses from April 2017 to February 2018 for medical/dental and nursing staff in urgent and emergency care is shown below:

Mandatory Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>41</td>
<td>52</td>
<td>78.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>39</td>
<td>52</td>
<td>75.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>38</td>
<td>52</td>
<td>73.1%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>29</td>
<td>50</td>
<td>58.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>29</td>
<td>52</td>
<td>55.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>29</td>
<td>52</td>
<td>55.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Counter Fraud</td>
<td>29</td>
<td>52</td>
<td>55.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>28</td>
<td>52</td>
<td>53.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>26</td>
<td>52</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine Management</td>
<td>13</td>
<td>52</td>
<td>25.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
The trust targets were not met for any of the 10 mandatory training modules shown above for medical staff. Of the modules where a target was set, dementia training module had the lowest completion rate with 19.2%. Of the modules where a target was not provided, medicine management and immediate life support training had low completion rates of 25.0% and 7.3% respectively.

### Mandatory Training Completion by module – Nursing Staff

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counter Fraud</td>
<td>112</td>
<td>126</td>
<td>88.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>111</td>
<td>126</td>
<td>88.1%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>109</td>
<td>126</td>
<td>86.5%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>89</td>
<td>126</td>
<td>70.6%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>88</td>
<td>126</td>
<td>69.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>81</td>
<td>125</td>
<td>64.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>74</td>
<td>126</td>
<td>58.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>71</td>
<td>126</td>
<td>56.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>70</td>
<td>126</td>
<td>55.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>67</td>
<td>126</td>
<td>53.2%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>31</td>
<td>72</td>
<td>43.1%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine Management</td>
<td>24</td>
<td>126</td>
<td>19.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>927</td>
<td>1,457</td>
<td>63.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust targets were met for three of the 10 mandatory training modules shown above for nursing staff. Of the modules where a target was set, infection control training module had the lowest completion rate with 53.2%. Of the modules where a target was not provided, immediate life support and medicine management training, both modules had low completion rates with 43.1% and 19.0% respectively.

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

### Safeguarding

#### Safeguarding training completion rates

The trust set a target of 80% for completion of safeguarding training.

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

### Safeguarding Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>35</td>
<td>52</td>
<td>67.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>33</td>
<td>52</td>
<td>63.5%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>104</td>
<td>65.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The 80% target was not met for either of the safeguarding training modules for which medical staff in urgent and emergency care were eligible. Safeguarding children had the lowest completion rate with 63.5%.

### Safeguarding Training Completion by module – Nursing Staff

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>102</td>
<td>126</td>
<td>81.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>44</td>
<td>126</td>
<td>34.9%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>146</td>
<td>252</td>
<td>57.9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 80% target for the safeguarding adults training module was met, but the target for the safeguarding children module was not. For the latter, there was a low completion rate of 34.9%, as at February 2018.

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

The lead for safeguarding confirmed nursing and medical staff working in the emergency department should have completed level three child safeguarding training. At the time of the inspection it was reported that trust-wide only sixty staff of a possible 178 had completed this training. The safeguarding team reported it was difficult for staff to be released from the department to attend training. They had therefore introduced in-reach training sessions, therefore allowing small numbers of staff to attend training during the working day.

The safeguarding team reviewed the care records for all children under the age of five who attended the department. Information would be shared with relevant authorities or health professionals for all such attendances. Staff had access to safeguarding child liaison forms for all non-urgent referrals; these were reviewed and assessed by the safeguarding team to determine the most appropriate course of action. Approximately 250 forms were completed from across both emergency departments each month demonstrating a good awareness of the forms and their purpose. The safeguarding team reported the most common reason for referral was associated with the presentation of parents to the emergency department, suggesting a good awareness of “Think child”.

There was representation of the specialty consultant for emergency medicine at local safeguarding meetings. Members of the safeguarding team attended band 7 meetings to update on elements of safeguarding practice, themes and trend analysis resulting from safeguarding referrals.

Staff had a good understanding of those patients who presented to the emergency department suspected of being a victim of female genital mutilation, child exploitation or slavery. Staff could describe the escalation pathways for such patients and the role they would play in the management of those patients. Staff we spoke with confirmed they had received update training in relation to these topics, as we all radicalisation of the young person however, we noted the low compliance with safeguarding training within the division.

There was a local policy in place which required staff to undertake a search of an “At risk” register when a child presented to the ED. This was to enable staff to make suitable provision for vulnerable children where required. An audit submitted by the trust revealed compliance with this process was poor, with checks only being undertaken in 50% of cases. This meant there was a risk of known vulnerable or at risk children presenting to the ED with no awareness of staff regarding the needs of the child or family. This was acknowledged as an area requiring improvement. Following the inspection, CQC used its enforcement powers to encourage the trust to make improvements in a number of areas. We will therefore continue to monitor the
compliance with safeguarding checks as part of our continued regulation of this service and trust.

**Cleanliness, infection control and hygiene**

**Royal Hampshire County Hospital**

Sharps bins were generally labelled and hung at appropriate heights and not over-full.

The clinical environment was visibly clean. The waiting areas at both the main reception area and of that within the minor’s assessment area were clean with no debris or litter noted.

Staff were observed to be conforming with bare-below the elbow practices during each of our inspection visits.

Hand hygiene audit results were consistently in the region of 90-100% for the period January 2018 to June 2018 (with the exception of February 2018 when compliance was recorded as 70%).

AuditR data suggested compliance with cleaning of commodes was varied although we noted the low number of commodes audited. In February 2018, March 2018 and June 2018 compliance was recorded as 0%, 66.6% and 50% respectively.

Compliance against peripheral cannula insertion was noted to be only 50% in February and June 2018. Again, it is important to note the low number of cases audited and so interpretation of the dataset should be done with caution.

We noted one patient within the short stay ward who had a diagnosis of viral gastritis and had been vomiting in the preceding twenty-four hours. We noted that despite the patient having a confirmed viral condition, no isolation sign was present warning visitors of the risk of viral contagion. A member of staff was observed moving a chair from the patient’s bedside and offering it to a visitor of another patient without first decontaminating the chair. We raised this with the staff member at the time who subsequently took action to clean the furniture so as to reduce the risk of cross-contamination.

**Basingstoke and North Hampshire Hospital**

Sharps bins were generally labelled and hung at appropriate heights and not over-full.

Cleaning lists were completed sporadically. We observed areas such as the main waiting area to be cluttered with litter, used tissues and disposable bowls. A member of nursing staff was observed cleaning the area during an unannounced inspection of the department out of hours. We observed housekeeping staff cleaning around furniture and equipment rather than moving equipment out of the way. Significant dust was found under the desk within the short stay ward and within the SSU notes trolley.

One relative raised a concern that they observed a “Wet floor” warning sign that was labelled “Kitchen” being placed in a toilet. We noted this warning sign to still be in situ in the vicinity of the toilet one hour after the relative had raised the concern.

One parent raised a concern that biscuits and other food stuffs had been left on the floor in the children’s waiting area. They were concerned because their child had significant dietary intolerances and so worried for their child’s welfare. The parent reported their concerns to a member of staff however, no action was taken until we escalated the concern.

Whilst the majority of staff who worked in the department complied with bare below the elbow guidance, visiting medical staff were observed wearing wristwatches and long sleeves. This meant they could not fully decontaminate their hands and lower arms between patient contacts.
Environment and equipment

Royal Hampshire County Hospital

Equipment was stored appropriately and there was evidence it had been serviced recently.

The local team reported an increase in the number of patients presenting to the department with both chronic and acute on-set mental health conditions. In part, this was due to the close proximity of a young offenders service, which was located near to the hospital. The trust had been slow to establish an appropriate environment in which patients could be accommodated. Staff had identified an area for conversion however this work had not yet been completed at the time of the inspection.

Royal Hampshire County Hospital did not have a designated mental health assessment room. Rooms they used were not safe as they contained ligature points. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

Throughout the whole emergency department we noted a significant number of ligature points. We asked the trust to provide us with the environmental risk assessment that should have been completed to describe how such risks were being effectively managed. The trust reported “The health and safety team have identified in the 2018/19 Q1 health and safety report that environmental audits for ligature points are required in high risk areas such as ED and these will be reported on in the Q2 report.”

In the HHFT emergency department’s team take mitigating actions in the event that a patient is identified as being at risk of self-harm. This includes the provision of 1:1 care if necessary and risk assessed care and treatment in the department.” (RN5148). We therefore concluded that no environmental risk assessments had been completed to support the mitigation against self-harm or possible suicide attempts by way of the identified ligature points.

We noted that a resuscitation bay had been designated for the stabilisation and treatment of children. During our inspection we observed the bay to be in frequent use for adult patients. We noted the resuscitation area was frequently at full capacity.

There was gaps in the checks of the resuscitation trolley which meant staff could not always be assured the trolley was fully stocked in the event of an emergency situation.

Children who presented to the emergency department were initially triaged and then directed to wait in a children’s waiting area within the main reception, or if they were identified as a minor’s patient, they were directed to the children’s waiting area within the minor’s area. Neither area had dedicated secure access to prevent unauthorised persons from entering the area.

Further, the waiting area was not directly supervised by a member of clinical staff and so there was a reliance on family members reporting a deterioration in their child’s condition. We noted that staff did not routinely access the area or undertake physical observations of children on a frequent basis whilst children waited to be seen by a clinician. This meant children were at risk of deterioration without early detection or intervention. We raised this issue with the trust and utilised our enforcement powers requiring the trust to take immediate action to resolve this issue.

Basingstoke and North Hampshire Hospital

There was an acknowledgement amongst all staff that we spoke with that the emergency department was no longer fit for purpose in terms of providing modern healthcare to an ever-increasing population. Daily attendances at the ED continually reached 200 patients which presented challenges to the team in terms of accommodating such high levels of attendance.
The department was poorly designed in that a high level of foot traffic was noted to occur through the major’s area. Patients were placed in different parts of the department which often led to confusion as to which pathway particular patients were on. For example, in the main waiting area, patients could be waiting to receive care from those supporting the minor’s pathway, major’s pathway or awaiting to see a General Practitioner. Whilst the triage nurse and ENP team acknowledged their responsibility for the waiting area, they reported it was often difficult to monitor who was who within the department. This created a potential risk within the department as it meant patients might not receive routine observations whilst waiting for additional tests or treatments.

We observed dedicated doors with “Keep shut” labels on them propped open with chairs in the clinical area.

The local team reported an increase in the number of patients presenting to the department with both chronic and acute on-set mental health conditions. In part, this was due to the close proximity of a third party mental health service, which was located near to the hospital. Despite the increase in activity for this group of patients, the trust had been slow to establish an appropriate environment in which patients could be accommodated. During our inspection of the ED in 2015 we reported the room used for the assessment of patients with mental health problems had neither a dedicated escape route or assistance alarm. During this inspection, the trust had identified an area within the short stay ward that could be used to accommodate patients deemed as low risk of self-harm or violent behaviour. The room contained ligature points; a ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The room was fitted with an emergency alarm that was accessible from anywhere in the room. The assessment room had two entry points; one of these was a door that opened both ways. Toilet facilities were located across the corridor and contained a significant number of ligature risks. There was a large chair and side-cupboard in the room which were not fixed to the wall; these two pieces of furniture could be used as projectiles, causing harm to staff, patients or visitors. Staff reported they also used an interview room located directly in front of the nurse’s station in the major’s area for the observation of mental health patients. This room had only one access point and again had multiple ligature points including exposed pipes from radiators. There were multiple large items of unsecured furniture which again could be used as a projectile. Staff reported the furniture had only recently been replaced due to the previous furniture being destroyed by a patient.

Throughout the whole emergency department we noted a significant number of ligature points. We asked the trust to provide us with the environmental risk assessment that should have been completed to describe how such risks were being effectively managed. The trust reported “The health and safety team have identified in the 2018/19 Q1 health and safety report that environmental audits for ligature points are required in high risk areas such as ED and these will be reported on in the Q2 report.”

In the HHFT emergency department's team take mitigating actions in the event that a patient is identified as being at risk of self-harm. This includes the provision of 1:1 care if necessary and risk assessed care and treatment in the department.”(RN5148). We therefore concluded that no environmental risk assessments had been completed to support the mitigation against self-harm or possible suicide attempts by way of the identified ligature points. Staff reported furniture had recently been replaced due to patients destroying chairs during violent episodes. There had been a lack of learning from those incidents. Staff reported they completed a risk assessment for patients with a mental health diagnosis. The risk assessment included risks to self, risk to other and risk of taking an overdose in the emergency department. The risk assessment included space
for staff to write an action plan to reduce identified risks. The risk assessment was an internally produced form. Staff used risk judgements to determine where to place patients with a mental health diagnosis. These judgements were based on experience, information obtained from the patient and the risk assessment form. Patients deemed to be high risk of self-harming were nursed on majors near the nurses’ station. Therefore, whilst the department had not fully and robustly considered the implications of having unmanaged and mitigated risk assessments in place for the management of ligature points, there was an awareness amongst staff regarding where high-risk patients should be nursed whilst in the ED.

We noted that a resuscitation bay had been designated for the stabilisation and treatment of children. During our inspection we observed the bay to be in frequent use for adult patients. We noted the resuscitation area was frequently at full capacity. Whilst we did not observe it, staff reported they often used a bed space in majors as an additional resuscitation area due to the resuscitation room being too small to meet current demand.

The department was cluttered with trolleys, hoists and wheelchairs lined against corridor walls adding to the overall cramped feel of the department.

There were gaps in the checks of resuscitation trolleys which meant staff could not always be assured the trolley was fully stocked in the event of an emergency situation.

Children who presented to the emergency department were initially streamed and then directed to wait in a children’s waiting area. This waiting area was located away from the main waiting room although did not have secure access to prevent unauthorised persons from entering the area. Further, the waiting area was not supervised by a member of clinical staff and so there was a reliance on family members reporting a deterioration in their child’s condition. We noted that staff did not routinely access the area or undertake physical observations of children on a frequent basis whilst children waited to be seen by a clinician. This meant children were at risk of deterioration without early detection or intervention. We raised this issue with the trust and utilised our enforcement powers requiring the trust to take immediate action to resolve this issue.

We inspected the department on 30 July to assess the improvements made. The trust had relocated the children’s waiting area to a side room immediately leading off the main waiting area. The trust had introduced an hourly rounding protocol in which children would have their observations completed and an early warning score calculated. We reviewed the care records for five children who had been admitted to the ward. Two children had no record of rounding having been undertaken despite the child being in the department for some three hours. However, a subsequent audit submitted by the trust indicated an overall improvement in compliance with paediatric rounding with 100% of audited records being compliant on 7 August 2018.

There was a lack of resuscitation equipment within the Minors area; there was a lack of risk assessment in place for this. Staff reported they would call for a resuscitation trolley to be brought from the major’s area, therefore depleting the available equipment within a high-risk clinical area.

**Assessing and responding to patient risk**

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all five 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</td>
<td>8.7</td>
<td>About the same</td>
</tr>
</tbody>
</table>
the ambulance crew before your care was handed over to the emergency department staff?

Q8. How long did you wait before you first spoke to a nurse or doctor?

6.7 About the same as other trusts

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?

6.5 About the same as other trusts

Q33. In your opinion, how clean was the emergency department?

8.4 About the same as other trusts

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?

9.7 About the same as other trusts

(Source: Emergency Department Survey – September 2016)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The trust’s median time from arrival to initial assessment was better than the overall England median in all months over the 12 month period from March 2017 to February 2018. In the latest period, February 2018 the median time to initial assessment was three minutes, compared to the England average of nine minutes.
Ambulance – Time to initial assessment from March 2017 and February 2018 at Hampshire Hospitals NHS Foundation Trust

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

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

From April 2017 to October 2017 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes across the trust. However, in December 2017 performance at the trust declined with 53% of ambulance journeys trust-wide having turnaround times over 30 minutes.

In the latest period, March 2018, 37% of ambulance journeys at Royal Hampshire County Hospital had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes – Royal Hampshire Hospital**

**Ambulance: Percentage of journeys with turnaround times over 30 minutes – Royal Hampshire County Hospital**
In the latest period, March 2018, 46% of ambulance journeys at Basingstoke and North Hampshire Hospital had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes – Basingstoke and North Hampshire Hospital**

```
<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Journeys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>500</td>
</tr>
<tr>
<td>May-17</td>
<td>550</td>
</tr>
<tr>
<td>Jun-17</td>
<td>600</td>
</tr>
<tr>
<td>Jul-17</td>
<td>650</td>
</tr>
<tr>
<td>Aug-17</td>
<td>700</td>
</tr>
<tr>
<td>Sep-17</td>
<td>750</td>
</tr>
<tr>
<td>Oct-17</td>
<td>800</td>
</tr>
<tr>
<td>Nov-17</td>
<td>850</td>
</tr>
<tr>
<td>Dec-17</td>
<td>900</td>
</tr>
<tr>
<td>Jan-18</td>
<td>950</td>
</tr>
<tr>
<td>Feb-18</td>
<td>1000</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1050</td>
</tr>
</tbody>
</table>
```

**Ambulance: Percentage of journeys with turnaround times over 30 minutes – Basingstoke and North Hampshire Hospital**

(Source: National Ambulance Information Group)
Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From March 2017 to March 2018 the trust reported 352 “black breaches” trust-wide. From March to November 2017 there was an upward trend, and December 2017 saw the highest amount of “black breaches” with 91.

(Royal Hampshire County Hospital
Staff at RHCH operated a different model of care for those patients arriving to the ED on foot then that on offer at Basingstoke and North Hampshire Hospital. All patients were initially booked in by a member of reception staff before being assessed by a triage nurse. An initial history and physical observations were taken before the patient was then allocated to the most appropriate clinical pathway, be it majors or minors (emergency nurse practitioner led). The triage process permitted nursing staff the flexibility to prioritise patients on clinical need as compared to time of arrival. Triage nurses undertook supplementary training to undertake triage which included both child and adult competencies.

Risk assessment for risks to self, risk to other and risk from others were not routinely completed for patients with a mental health or learning disability diagnosis. Staff at Royal Hampshire County Hospital would document risks in clinical notes. These assessments were made based on the clinician’s experience and risks they identified. A standardised risk assessment form was not used.

Staff used risk judgements to determine where to place patients with a mental health diagnosis. These judgements were based on experience and information obtained from the patient, rather than a formal assessment process. Patients deemed to be high risk of self-harming were nursed on majors near the nurses’ station. Nurses would remove any items patients could use to harm themselves, such as tubes and wires from cubicles, however ligature risks would remain. Low risk patients were nursed on the short stay ward. Staff explained the two side rooms in short stay were used for low risk mental health patients.

Royal Hampshire County Hospital did not have a designated mental health assessment room.
Rooms they used were not safe as they contained ligature points. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We reviewed the care records for three patients who had presented with mental health concerns. Whilst there was a recorded physical assessment for each patient, one patient had been in the department for three hours and despite having suicidal thoughts, no risk assessment had been completed.

We inspected the department on 30 July to assess the improvements made. The trust had introduced an hourly rounding protocol in which children would have their observations completed and an early warning score calculated. The trust submitted three audits of randomly selected notes for children who presented to the ED between 27 July and 7 August 2018. The audits confirmed children were consistently triaged, assessed, admitted or discharged in line with national standards. 93% of children had a set of observations recorded at triage. Hourly rounding was completed in only 33% of cases; there was an acknowledgment of the need to improve the frequency of rounding to ensure patients waiting more than one hour underwent additional observations to help determine and recognise the deteriorating child.

We reviewed ten sets of notes associated with patients who had attended the emergency department during the previous 48 hours. In one case we noted a patient had received antibiotics for the management of sepsis within thirty minutes of arrival. Whilst sepsis had been treated in line with national standards, no screening tool had been adopted despite this being advertised across the emergency department.

We noted one patient who had presented with a head injury. They were in the department for three hours 57 minutes. Despite their initial presentation of head injury, no neurological observations had been completed.

Another patient had presented with chest pain. Despite being in the department for three hours, only one set of observations were recorded and very limited nursing notes made.

One patient presented with an increase in falls whilst at home. Despite their presentation, no falls risk assessment was completed.

Whilst there was an awareness amongst staff of the use of sepsis assessment tools and pathways, we found staff were often commencing the checklists but then aborting them or failing to fully complete them with no record as to why that may be. There was a lack of governance and oversight of this area and so it was not possible to fully assess the extent of the issue and whether the department was taking robust action to resolve the poor compliance.

**Basingstoke and North Hampshire Hospital**

Between 08:00 and 11pm, the service adopted both a streaming and triage process for patients who presented on foot to the main emergency department. After 11pm there was no triage nurse and so reception staff were required to alert staff working in the major’s area of any patient presenting to the reception area. An initial history was taken and the patient was then streamed to the most appropriate clinical pathway, be it majors, minors (emergency nurse practitioner led) or to the General Practice service co-located in the department. Once streamed, a triage nurse would call the patient for initial observations to be completed.

During the inspection we observed that physiological and/or neurological observations were not always completed either comprehensively (physiological parameters such as blood pressure not recorded), or were completed infrequently. For example we noted a patient who had been brought in by ambulance with a head injury and cellulitis of the leg. The patient had a large orbital hematoma (bruising around the eye). The patient had been placed in the waiting area with no neurological or head injury red flag monitoring being commenced. A second patient presented...
with abdominal pain and had been in the department for 2 hours 50 minutes. The patient had not been seen since initial triage and had not received any further observations. Clinical staff would therefore have not been able to detect any subtle deterioration in the patient’s condition. A third patient was noted to be in the major’s area having sustained an injury to their ankle. Despite reporting numbness to their foot, no circulatory observations had been commenced. The patient reporting being in pain at 2 hours 43 minutes from presentation, had been offered no supplementary analgesia other than that provided by the ambulance crew, and despite asking nursing staff. Our specialist advisor escalated the care of the individual to nursing staff who then promptly administered analgesia. At 2 hours 45 minutes, it was noted the patient had received only one set of observations despite being in the department for 2 hours 45 minutes.

We reviewed four sets of notes for patients receiving care within the short stay unit at Basingstoke and North Hampshire Hospital. We noted one NEWS score miscalculated; one patient with a NEWS of six had no recorded action or escalation; no falls risk assessment for a patient who had been admitted following a fall; no visual infusion phlebitis score for patients who had been on the unit for more than 24 hours; drugs completely omitted for one patient with no explanation recorded on the medicine chart; no neurological observations for a patient who had been administered a sedative due to concerns of a head injury causing altered behaviour.

There was limited awareness amongst nursing staff of the use of sepsis screening tools and associated stickers.

Prior to inspecting regulated services, we routinely ask organisations to submit a range of information to us so we can consider additional lines of enquiry. The trust submitted an audit of their performance against compliance with completion of early warning charts. Whilst data was provided for the ED located at Royal Hampshire County Hospital, there was no data available for the ED at Basingstoke and North Hampshire Hospital. This lack of oversight, and our observations of poor compliance with trust policies on the use of and appropriate escalation of deteriorating patients, completion of falls risk assessments, completion of neurological observations for those with suspected head injuries and those receiving intravenous medicines meant patients were at risk of receiving sub-standard care.

Following our inspection, we used our enforcement powers and imposed conditions on the trust’s registration requiring them to take action to resolve the issue of poor compliance with tools such as early warning systems and sepsis pathways. We will continue to monitor the trusts performance to ensure appropriate improvements are made.

**Nurse staffing**

The trust has reported their nursing staffing numbers for urgent and emergency care trust-wide below as at February 2018, with a staffing rate of 78.8%.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at February 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire Hospitals NHS Foundation Trust</td>
<td>139.1</td>
<td>109.6</td>
<td>78.8%</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From March 2017 to February 2018, the trust reported a vacancy rate of 16.4% in urgent and emergency care trust-wide, compared to the 8% provisional trust target.)
• Royal Hampshire County Hospital (ED): 18.7%
• Basingstoke and North Hampshire Hospital (ED): 11.3%

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

Turnover rates

From March 2017 to February 2018, the trust reported a turnover rate of 18.7% in urgent and emergency care trust-wide, compared to the 12% provisional trust target.

• Royal Hampshire County Hospital (ED): 13.7%
• Basingstoke and North Hampshire Hospital (ED): 19.9%

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

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 3.9% in urgent and emergency care trust-wide, compared to a 3.5% provisional trust target.

• Royal Hampshire County Hospital (ED): 3.4%
• Basingstoke and North Hampshire Hospital (ED): 4.3%

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

Bank and agency staff usage

Please note that we are unable to calculate bank and agency usage as a proportion of the total number of shifts available, including those covered by permanent staff, due to the fact that the trust was unable to provide the total number of available shifts.

The below table shows total shifts filled by bank/agency qualified nursing staff and shifts left unfilled from March 2017 to February 2018 in urgent and emergency care:

<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and North Hampshire Hospital</td>
<td>886</td>
<td>2,660</td>
<td>1,044</td>
</tr>
<tr>
<td>Royal Hampshire County Hospital</td>
<td>2,168</td>
<td>1,765</td>
<td>906</td>
</tr>
</tbody>
</table>

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

Royal Hampshire County Hospital

At the time of our inspection the department had no nurses who were trained in children’s nursing. This meant the department could not meet the Royal College of Nursing (RCN) guidance: defining staffing levels for children and young people’s services and RCEM emergency department care guidance which states one registered nurse (children) should be on each shift in a mixed emergency department. Following our inspection, the trust took action to mitigate this risk by ensuring all a range of nurses and doctors completed paediatric intermediate life support training. This ensured that on each shift there would be at least one member of staff who had more advanced paediatric life support training than other staff. This did not however address the issue of staff having sufficient knowledge of identifying when a paediatric patient was deteriorating.
Following the inspection, the trust provided data to demonstrate that there was at least one member of staff on each shift who held advanced paediatric life support qualifications. A competency framework had also been developed to support increasing the competency of adult nurses in the management of children. In addition to this mitigation, we were additionally assured by the close proximity and developed working relationships between the ED team and the children’s assessment ward which was co-located alongside the emergency department. Staff from both departments reported robust working practices, including joint governance meetings for paediatrics.

**Basingstoke and North Hampshire Hospital**

At the time of our inspection the department had four nurses who were dual trained in adult and children’s nursing. This meant the department could not meet the Royal College of Nursing (RCN) guidance: defining staffing levels for children and young people’s services and RCEM emergency department care guidance which states one registered nurse (children) should be on each shift in a mixed emergency department. Whilst the department reported they had attempted to mitigate this risk by ensuring a range of nurses and doctors completed paediatric intermediate life support training, this could not initially be evidenced. The leadership team also reported that all nursing staff completed a competency framework which included specific competencies for the management of children. We asked the trust to provide us with the information which demonstrated the number of staff who had been assessed as competent and who had completed the framework; the trust was not able to provide this information at the time of the inspection as it was not an area that had previously been monitored.

Whilst a number of staff had completed paediatric immediate life support training, this did not however address the issue of staff having sufficient knowledge of identifying when a paediatric patient was deteriorating. Following the inspection, the trust provided data to demonstrate that there was at least one member of staff on each shift who held advanced paediatric life support qualifications. A competency framework had also been developed to support increasing the competency of adult nurses in the management of children. It was however too soon for us to consider the impact that these actions had had and will follow-up accordingly with the trust at an appropriate time.

**Medical staffing**

The trust has reported their medical staffing numbers for urgent and emergency care trust-wide below as at February 2018, with a staffing rate of 67.7%.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at February 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire Hospitals NHS Foundation Trust</td>
<td>64.3</td>
<td>43.5</td>
<td>67.7%</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From March 2017 to February 2018, the trust reported a vacancy rate of 12.9% in urgent and emergency care trust-wide, compared to the 8% provisional trust target.

- Royal Hampshire County Hospital (ED): over-established by 380.9%
For medical staff, the majority of over-establishment is due to the GP’s salaries that the trust hosts, of which over 30 new posts were added during the year in which they did not plan for.

Some cost centres apply to multiple sites. In these cases there is no division within the budget between the sites, so it was not possible to produce site level vacancy rates.

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

**Turnover rates**

From March 2017 to February 2018, the trust reported a turnover rate of 44.1% in urgent and emergency care trust-wide, compared to the 12% provisional trust target.

- Royal Hampshire County Hospital (ED): 51.4%
- Basingstoke and North Hampshire Hospital (ED): 39.5%

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

**Sickness rates**

From March 2017 to February 2018, the trust reported a sickness rate of 0.9% in urgent and emergency care trust-wide, compared to a 3.5% provisional trust target.

- Royal Hampshire County Hospital (ED): 1.5%
- Basingstoke and North Hampshire Hospital (ED): 1.0%

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

**Bank and locum staff usage**

Please note that we are unable to calculate bank and locum usage as a proportion of the total number of shifts available, including those covered by permanent staff, due to the fact that the trust was unable to provide the total number of available shifts.

The below tables show total shifts filled by bank/locum medical staff from March 2017 to February 2018 in urgent and emergency care at Hampshire Hospitals NHS Foundation Trust across multiple sites; there was no data for how many shifts were not filled:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by locum staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor in training</td>
<td>279</td>
<td>950</td>
</tr>
<tr>
<td>Middle grade</td>
<td>66</td>
<td>N/A</td>
</tr>
<tr>
<td>Consultant</td>
<td>N/A</td>
<td>52</td>
</tr>
<tr>
<td>Total</td>
<td>345</td>
<td>1,002</td>
</tr>
</tbody>
</table>

The trust stated that the area that had the highest bank or agency usage and current vacancy rate in urgent and emergency care was as below, although they did not state what this was mainly attributed to:

<table>
<thead>
<tr>
<th>Ward/ area name</th>
<th>Bank Use</th>
<th>Agency Use</th>
<th>Current Vacancy Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unscheduled Care Medical Staff</td>
<td>2.68</td>
<td>5.51</td>
<td>55.68%</td>
</tr>
</tbody>
</table>

The unscheduled care medical staff bank and agency usage and current vacancy rate was across both medicine and urgent and emergency care core services combined, as provided by
the trust.

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

Staffing skill mix

In January 2018, the proportion of consultant staff reported to be working at the trust were about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 42 whole time equivalent staff working in Urgent and Emergency Care at Hampshire Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>40%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior</td>
<td>31%</td>
<td>23%</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)

The local management team, and a review of July 2018 board papers confirmed the trust had experienced difficulties in recruiting to middle grade medical roles. Staff we spoke with told us there were currently 6.8 whole time equivalent middle-grades to support two emergency departments. It was acknowledged that this was not a sustainable model and the trust was working with Health Education England and other stakeholders to develop a long term, sustainable staffing model. Junior medical staff we spoke with reported that whilst the support from consultants was generally good, the workload meant educational opportunities were frequently lacking. We had noted during a lunchtime “Board round” that time had been allocated at the end of the round for an educational session facilitated by the consultant.

Staff across all levels reported the most significant deficit was at night-time when there was a reliance on the use of locum middle grade doctors, with no direct consultant oversight. As a mitigation to the staffing challenges, consultants reported they frequently “Acted down” to support the department.

Board papers for July 2018 confirmed the trust had approved the recruitment of an additional six whole time consultants to work within both emergency departments. Whilst the trust had one consultant who had specialist paediatric training, the trust was to undertake recruitment of an additional consultant with specialist training to help further develop children’s emergency medicine at the trust.
Records

The department used a range of electronic and paper based records. The majority of documentation was by way of paper records which were then scanned on to the computer once the patient had been discharged from the ED. Staff would photocopy care records should the patient either be admitted or discharged to another care provider such as a tertiary hospital.

Royal Hampshire County Hospital

We reviewed thirteen patient records during our inspection. We found the quality of records and contemporaneous notes to be varied. One nurse for the department confirmed significant improvements were required in regards to the documentation used, and compliance with good record keeping records standards. This was further reiterated within AuditR records which demonstrated consistently poor compliance with NEWS compliance within the RHCH ED.

Basingstoke and North Hampshire Hospital

Access to electronic records was by way of password-protected databases. However, we noted throughout our inspection, various computers remained unlocked and whilst limited in the range of information on show, it was possible to read screens which contained the names of patients within the department.

We reviewed 25 patient records during our inspection. We found the quality of records and contemporaneous notes to be varied. The lead nurse for the department confirmed significant improvements were required in regards to the documentation used, and compliance with good record keeping records standards.

Medicines

Royal Hampshire County Hospital

We noted a cabinet containing intravenous fluids (with potassium) stored in a closed but unlocked cupboard. One set of medical records did not contain the batch number for the intravenous fluid administered.

Emergency nurse practitioners were responsible for the security of medicines keys within the minor’s areas. During the inspection we found the ENP had hold of the keys and kept them on their person. However, we was told that keys were often left hanging in an unsecure area of the minor’s area for convenience.

FP10 prescription pads were held securely with appropriate governance supporting their use. This reduced the risk of prescription pads being misused or stolen from the department.

Between 1 January 2018 and 30 June 2018 the department reported 17 medication incidents. There was limited investigation against a number of incidents to determine how processes had been improved. A number of incidents simply had “All appropriate actions complete” listed within the lessons learnt section.

Basingstoke and North Hampshire Hospital

We noted a medicine cabinet located in the triage room situated in main waiting area was unlocked. The cabinet contained a range of medicines. There were multiple occasions when the room was observed to be unattended. The door of the cabinet was labelled stating it should remain locked at all times.
Between 1 January 2018 and 30 June 2018 the department reported 37 medication incidents. A proportion of incidents related to temporary members of staff making errors. There was limited investigation against a number of incidents to determine how processes had been improved, especially in regards to the administration of medicine by temporary staff.

We noted that fridge temperatures were not always routinely monitored. This was despite an incident reported in which medicines stored in a fridge in the resuscitation room had been found frozen. The action was to add fridge temperature checking to daily checklist. This would suggest the learning had not been widely cascaded and that learning from the incident had not been embedded in practice.

**Incidents**

**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 April 2017 to March 2018, the trust reported one incident classified as a never event for urgent and emergency care. This was for misplaced naso- or oro-gastric tubes in July 2017 at Basingstoke and North Hampshire Hospital.

*(Source: Strategic Executive Information System (STEIS))*

**Royal Hampshire County Hospital**

A review of incidents suggests limited insight in to extracting lessons learnt despite themes being apparent from reported incidents. In a significant proportion of incidents, lessons learnt were captured as “All appropriate actions taken”.

Learning was reported to be disseminated via team meetings and email (amongst the ENPs). Staff could describe subtle changes to practice which had occurred as a result of previous incidents. Whilst there was extremely limited cross-site working and learning, staff working at Royal Hampshire County Hospital could recollect the main learning points from a never event which had occurred at Basingstoke and North Hampshire Hospital. We noted that learning from incidents was starting to be relayed to staff using a weekly “Commcell”. This was a short meeting held within the ED each Tuesday to consider the previous week’s performance, and specific events (and learning) and any actions for the following week. The Commcell was used as a means of improving communication within the ED and for informing staff of improvements against performance. With the exception of learning from notable events, there appeared limited information to drive a wider quality agenda.

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 were familiar with duty of candour and the concepts of openness and transparency. Senior staff and clinicians demonstrated a more in-depth knowledge of the duty of candour and gave examples of serious incidents when they had implemented the duty of candour.

Morbidity and mortality meetings were held to facilitate the review of patient deaths and those incidents resulting in significant morbidity for patients accessing the emergency department. Paediatric morbidity and mortality meetings had commenced in June 2018 and were facilitated by
the specialist ED consultant. The meeting was noted to use comprehensive data sets with appropriate discussion of cases including patients who had died or who had presented to the ED and then subsequently transferred to a tertiary centre. It was recognised that a need for formal debriefs of staff was important and was listed as a learning point. The pre-alert of children was also noted as a learning point in two cases of children transferred to a tertiary centre. Staff we spoke with could describe the importance of raising a pre-alert with the paediatric team which suggests learning points from the MM process had been disseminated to local staff.

Basingstoke and North Hampshire Hospital

Staff we spoke with were able to describe the learning which derived from a never event within the department. A review of records confirmed that staff were undertaking a range of checks to ensure naso-gastric tubes were correctly placed. Staff could describe the process of escalating checks to include x-ray where there was uncertainty of the position of a naso-gastric tube where aspiration was in-conclusive or not possible.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in urgent and emergency care trust-wide which met the reporting criteria set by NHS England where the incident occurred between April 2017 and March 2018.

Two of these serious incidents occurred at Royal Hampshire County Hospital. The types of incident reported were:

- Slips/trips/falls meeting SI criteria – one incident
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) – one incident

One of these serious incidents occurred at Basingstoke and North Hampshire Hospital and was recorded as a medical equipment/devices/disposables incident meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

Basingstoke and North Hampshire Hospital

One incident was reported as major; five as moderate; 47 as minor and 315 as no harm. Three incidents had no harm consequence listed.

A review of incidents suggests a limited lack of insight in to extracting lessons learnt despite themes being apparent from reported incidents. There was a reliance on staff completing reflective documents, which, whilst helping to raise the insight of an individual, does not support systematic changes to practice. Learning was reported to be disseminated via team meetings however staff could not report any significant changes to practice having occurred as a result of incidents being reported. However, we noted that learning from incidents was starting to be relayed to staff using a weekly “Commcell”. This was a short meeting held within the ED each Tuesday to consider the previous week’s performance, and specific events (and learning) and any actions for the following week. The Commcell was used as a means of improving communication within the ED and for informing staff of improvements against performance. With the exception of learning from notable events, there appeared limited information to drive a wider quality agenda.

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**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 seven new pressure ulcers, 10 falls with harm and 18 new urinary tract infections in patients with a catheter from April 2017 to April 2018 within urgent and emergency care.
Is the service effective?

Evidence-based care and treatment

Policies, procedures and clinical guidelines were based on evidence-based best practice and relevant legislation and were accessible to all staff members. We saw that the department implemented relevant clinical guidelines from the National Institute for Health and Care Excellence (NICE) and other relevant professional bodies such as the Royal College of Emergency Medicine (RCEM).

A range of evidence based risk assessments and tools were used within the department. These included the SBAR (situation, background, assessment and recognition) tool when communicating with other staff members about patient’s clinical condition.

We found that whilst staff had access to guidance which was based on national best practice, such as Management of the deteriorating patient, staff did not consistently use the tools and guidance available to them. Conversely, where staff used specific tools such as the national early warning tool, they did not always follow local policies in regards to the frequency of observations or the escalation of patients. This was supported by information reviewed during the inspection via the “AuditR” ward scorecard which revealed consistently poor compliance with NEWS scoring.

Nutrition and hydration

Emergency Department Survey 2016
In the CQC Emergency Department Survey, the trust scored 6.8 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 than other trusts.

(Source: Emergency Department Survey – September 2016)

Documentation was used for the assessment of patients at risk of malnutrition or dehydration. A review of thirteen records at Royal Hampshire County Hospital and 25 records at Basingstoke and North Hampshire Hospital confirmed that where it was considered appropriate, staff undertook appropriate risk assessments. However, a review of Audit R scorecards revealed a lack of audit activity in relation to nutritional risk assessments and so the trust cannot be assured of the process undertaken by staff to consistently complete nutritional risk assessments.

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 7.2 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was better than other trusts.

The trust scored 7.5 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>7.2</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey – September 2016)

Overall, there was a lack of audit activity undertaken by the trust to help the consider whether they undertook pain management in an effective way. The audit lead confirmed the department had not participated in the 2017 Royal College of Emergency Medicine Pain audit for children.

At Basingstoke and North Hampshire Hospital, a patient was noted to be in the major’s area having sustained an injury to their ankle. Despite reporting numbness to their foot, no circulatory observations had been commenced. The patient reported being in pain 2 hours 43 minutes from presentation but had been offered no supplementary analgesia other than that provided by the ambulance crew, and despite asking nursing staff. Our specialist advisor escalated the care of the individual to nursing staff who then promptly administered analgesia.

We reviewed thirteen sets of notes at Royal Hampshire County Hospital and 25 at Basingstoke and North Hampshire Hospital. The completion of pain scores was sporadic. Where initial pain scores had been taken and analgesia provided staff then did not routinely follow up whether the intervention had had the desired outcome or whether staff should progress along the analgesia ladder.

We asked staff how they assessed the pain levels of children or those who could not effectively communicate. We were shown age specific observation charts for children which included a section for the assessment of pain scores on a numerical range from 0-10 for 1-4 year olds and
13-18 years. There was no pain section on the PEWS charts for 5-12 years or 0-1 years. Whilst the use of numerical pain assessments tools are likely appropriate for older children, they are less effective for younger children and so alternative evidence based tools have been developed. These alternative tools were not well known amongst the staff we spoke with during the inspection. At Basingstoke and North Hampshire Hospital, we observed one child who was diagnosed with a fractured bone. The child was observed to be distressed for some 2 hours whilst in the department. Whilst first line analgesia had been provided, no further intervention had been reported. The child and family had been placed in a bay within the majors department with no intervention of distraction therapies adopted to help manage the child’s clear anxiety and distress.

Minutes of an unscheduled care mortality, morbidity and governance meeting held on 20 March 2018 made reference to an audit in to dislocated shoulders presenting to the ED. It was noted within the minutes a comment made stating “documentation of paperwork relating to pain relief given to patients who present with this injury is sparse and lacking in detail across the board. What is needed is an overhaul of the sedation documentation. It would be good to have a tick box and date and time space to remind the staff to document these.” Despite clinical staff undertaking audits to improve quality within the department, there was limited evidence of positive outcomes, as was observed during the inspection through the lack of pain assessment and recording by clinical and nursing staff.

Patient outcomes

RCEM Audit: Moderate and Acute Severe Asthma 2016/17

Royal Hampshire County Hospital:

In the 2016/17 Moderate and Acute Severe Asthma report, Royal Hampshire County Hospital failed to meet any of the standards (which were all 100%).

The hospital was in the upper UK quartile for three standards:

- **Standard 4**: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. The hospital’s result was 95.7% compared to the UK average of 77.0%.

- **Standard 5a**: If not already given before arrival to the ED, steroids should be given as soon as possible according to guidelines, within 60 minutes of arrival (acute severe). The hospital’s result was 61.1% compared to the UK average of 19.0%.

- **Standard 5b**: If not already given before arrival to the ED, steroids should be given as soon as possible according to guidelines, within 4 hours (moderate). The hospital’s result was 81.3% compared to the UK average of 28.0%.

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

- **Standard 9**: Discharged patients should have oral prednisolone prescribed according to guidelines. The hospital’s result was 0.0% compared to the UK average of 52.0%.

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

Basingstoke and North Hampshire Hospital:

In the 2016/17 Moderate and Acute Severe Asthma report, Basingstoke and North Hampshire
Hospital failed to meet any of the standards (which were all 100%).

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

- Standard 2a: As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. The hospital’s result was 49.0% compared to the UK average of 26.0%.
- Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines. The hospital’s result was 76.2% compared to the UK average of 52.0%.

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

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Royal Hampshire County Hospital:

In the 2016/17 Consultant sign-off audit, Royal Hampshire County Hospital failed to meet the 100% standard in the one metric which was reported and was in the lower UK quartile: Standard 3: Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. The hospital’s result was 0.0% compared to the UK average of 12.0%.

Basingstoke and North Hampshire Hospital:

In the 2016/17 Consultant sign-off audit, Basingstoke and North Hampshire Hospital failed to meet the 100% standard in the one metric which was reported and was between the upper and lower UK quartile: Standard 3: Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. The hospital’s result was 18.2% compared to the UK average of 12.0%.

(Source: Royal College of Emergency Medicine)
RCEM Audit: Severe sepsis and septic shock 2016/17

Royal Hampshire County Hospital:

In the 2016/17 Severe sepsis and septic shock audit, Royal Hampshire County Hospital was in the upper UK quartile for two standards:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. The hospital’s result was 92.0% compared to the UK average of 64.6%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. The hospital’s result was 50.0% compared to the UK average of 18.4%.

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. The hospital’s result was 12.0% compared to the UK average of 69.1%.

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

Basingstoke and North Hampshire Hospital:

In the 2016/17 Severe sepsis and septic shock audit, Basingstoke and North Hampshire Hospital was in the upper UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. The hospital’s result was 82.0% compared to the UK average of 64.6%.

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. The hospital’s result was 20.0% compared to the UK average of 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)

RCEM Audit: Vital signs in children 2015/16

Royal Hampshire County Hospital:

In the 2015/16 Vital signs in children audit, Royal Hampshire County Hospital failed to meet any of the standards (which were all 100%).

The hospital was in the upper England quartile for one developmental standard:

- Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). The hospital’s result was 90.9%
compared to the England average of 69.7%.

For the remaining five metrics, the hospital was in the lower England quartile for two fundamental standards and three developmental standards:

- **Standard 1a (fundamental).** All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of: Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Hospital: 18.0%; England: 37.6%.

- **Standard 1b (developmental).** Capillary refill time. The hospital’s result was 6.0% compared to the England average of 22.5%.

- **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. The hospital’s result was 0.0% compared to the England average of 4.4%.

- **Standard 4 (fundamental).** There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. The hospital’s result was 45.5% compared to the England average of 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). The hospital’s result was 33.3% compared to the England average of 60.0%.

**Basingstoke and North Hampshire Hospital:**

In the 2015/16 Vital signs in children audit, Basingstoke and North Hampshire Hospital failed to meet any of the standards (which were all 100%).

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

- **Standard 1 (fundamental).** All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of: Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. The hospital’s result was 70.0% compared to the England average of 37.6%.

- **Standard 3 (developmental).** There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). The hospital’s result was 87.5% compared to the England average of 69.7%.

- **Standard 4 (fundamental).** There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. The hospital’s result was 93.8% compared to the England average of 73.2%.

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

(Source: Royal College of Emergency Medicine)
RCEM Audit: Procedural sedation in adults 2015/16

Royal Hampshire County Hospital:

The hospital did not submit data to this audit.

Basingstoke and North Hampshire Hospital:

In the 2015/16 Procedural sedation in adults audit, Basingstoke and North Hampshire 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 two developmental standards:

- Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. The hospital’s result was 82.0% compared to the England average of 51.8%.

- Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. The hospital’s result was 98.0% compared to the England average of 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
    The hospital’s result was 78.0% compared to the England average of 40.8%.

- Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
  - Standard 5a. Non-invasive blood pressure
  - Standard 5b. Pulse oximetry
  - Standard 5c. Capnography
  - Standard 5d. ECG
    The hospital’s result was 82.0% compared to the England average of 23.9%.

- Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. The hospital’s result was 98.0% compared to the England average of 41.0%.

The hospital was in the lower England quartile for one fundamental standard:

- Standard 1 (fundamental): Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
  - Standard 1a. ASA grading
  - Standard 1b. Prediction of difficulty in airway management
  - Standard 1c. Pre-procedural fasting status
    The hospital’s result was 0.0% compared to the England average of 7.6%.

The hospital’s result for the remaining metric was between the upper and lower England quartiles:

- 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 7b. (fundamental): Vital signs within normal limits for the patient
- 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. The hospital’s result was 4.2% compared to the England average of 2.6%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16**

**Royal Hampshire County Hospital:**

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit Royal Hampshire County Hospital met one the audit standards (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. The hospital’s result was 100%, which was the same as the England average 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. The hospital’s result was 57.6% compared to the England average of 2.0%.

**Basingstoke and North Hampshire Hospital:**

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit Basingstoke and North Hampshire Hospital failed to meet any of the audit standards (which were all 100%). The hospital was in the upper England quartile for one of the two standards:

- 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. The hospital’s result was 45.5% compared to the England average of 2.0%.

The hospital did not have a result for the remaining metric:

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

(Source: Royal College of Emergency Medicine)

**Unplanned re-attendance rate within 7 days**

From April 2017 to March 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average. In the latest period, March 2018, the trust’s performance was 6.8% compared to an England average of
7.6%. No data was available for October 2017.

Unplanned re-attendance rate within 7 days - Hampshire Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality)

Senior medical staff confirmed they had not participated in all applicable Royal College of Emergency Medicine audits for 2017. In part, this was associated to a lack of substantive medical workforce to enable the audits to be completed.

Following our inspection, we requested information on the departments audit programme and any reports form recently conducted audits. The information received showed the planned audits to be undertaken during this year. In total four items were on the programme, three of which were national Royal College of Emergency Medicine (RCEM) and a national Trauma Audit Research Network (TARN) audit. As all audits were either not started or in the data collection stages, there were no results, reports or action plans for these audits.

Competent staff

Appraisal rates

Royal Hampshire County Hospital
From April 2017 to February 2018, 29.8% of staff within urgent and emergency care at Royal Hampshire County Hospital had received an appraisal, compared to a trust target of 80% for non-medical staff and 90% for medical staff.

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

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number Completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>17</td>
<td>53</td>
<td>32.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>5</td>
<td>25</td>
<td>20.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>84</strong></td>
<td><strong>29.8%</strong></td>
</tr>
</tbody>
</table>

Medical/dental staff at Royal Hampshire County Hospital had a completion rate of 75%, whilst 32.1% of nursing staff had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
A number of staff reported they felt the appraisal process was meaningful and constructive. In the 2017 staff survey, 73% of staff working in unscheduled care reported having received an appraisal in the last 12 months. This was worse than the trust average of 78%.

17% of staff reported that organisational values were considered as part of the appraisal process. This was significantly worse than the trust average. However, 74% reported individual training and development needs were identified during the appraisal process; this was better than the trust average of 66%.

Staff grade doctors reported they received sufficient support from their consultants. However, due to the limited number of junior doctors, training opportunities were limited. This was reflected in the attendance lists for morbidity and mortality meetings in which very few people attended the meetings.

There was an acknowledgment amongst the nursing leadership for there to be significant improvements in understanding the competency of the workforce; the skill set of individuals; and for increasing the number of staff who had undertaken post-graduate training in emergency nursing. The department reported five members of staff had completed such training, as at the time of the inspection.

Nursing and medical staff relied upon security staff to manage patients or relatives who were violent or aggressive. This was because staff had not completed restraint or breakaway technique training.

Staff did not have the skills, knowledge and experience to identify and manage issues arising from patients’ mental health conditions, learning disability, autism or dementia. Staff received limited training on these conditions. Staff told us they learnt on the job and often relied upon carers, particularly for patients with learning disabilities and dementia. However, staff did have access to the dementia team. The dementia team worked across the hospital from 7am to 7pm every day.

Nursing staff worked with local mental health teams, social care and domiciliary support agencies where appropriate. Information was shared, although this was sometimes difficult due to differences in record keeping between different providers. For example, local mental health services used an electronic record system and the hospital used paper records.

**Basingstoke and North Hampshire Hospital**

From April 2017 to February 2018, 31.7% of staff within urgent and emergency care at Basingstoke and North Hampshire Hospital had received an appraisal, compared to a trust target of 80% for non-medical staff and 90% for medical staff.

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

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number Completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>7</td>
<td>15</td>
<td>46.7%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>21</td>
<td>60</td>
<td>35.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>11</td>
<td>46</td>
<td>23.9%</td>
</tr>
<tr>
<td>Qualified ambulance service staff</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
<td><strong>123</strong></td>
<td><strong>31.7%</strong></td>
</tr>
</tbody>
</table>

Medical/dental staff at Basingstoke and North Hampshire Hospital had a completion rate of 46.7%, whilst 35% of nursing staff had received an appraisal.

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*
We received mixed opinions from staff in regards to the appraisal process. A number of staff reported they felt the process was meaningful and constructive. Others reported they could not recall when they had last had an appraisal which added to an element of not feeling included within the directorate. In the 2017 staff survey, 59% of staff working in unscheduled care reported having received an appraisal in the last 12 months. This was worse than the trust average of 78%.

Trainee doctors reported they received sufficient support from their consultants. However, due to the limited number of junior doctors, training opportunities were limited. This was reflected in the attendance lists for morbidity and mortality meetings in which very few people attended the meetings. This restricted the ability of trainee doctors to learn. Three doctors raised significant concerns over the competency of staff to care for and manage children within the department. We have reported further on this within the safe domain.

There was an acknowledgment amongst the nursing leadership for there to be significant improvements in understanding the competency of the workforce; the skill set of individuals; and for increasing the number of staff who had undertaken post-graduate training in emergency nursing. The department reported five members of staff had completed such training, as at the time of the inspection.

**Multidisciplinary working**

During our inspection we observed examples of effective multidisciplinary team working and mainly positive feedback about relationships with different departments and staff groups. However, we were also informed of some challenges experienced within the department. Senior staff told us about the challenges they had faced in getting specialist teams to attend the department to review patients when emergency physicians had identified which speciality they would need referral to.

**Royal Hampshire County Hospital**

However, a number of clinical pathways including stroke, were well established and were seen to function well during the inspection. Staff were pre-alerted to the arrival of patients suspected of suffering from a stroke. ED staff and specialist nursing staff were observed working well together to deliver holistic care.

**Basingstoke and North Hampshire Hospital**

There were examples of positive practice with the development of RemED treatment pathways which were being introduced to try and direct patients who met specific criteria, to the right clinical pathway without the need to be seen and treated in the ED setting. Further, the team was working with the local ambulance trust to develop some seven clinical pathways which would enable ambulance crews to bypass ED altogether, and permit them to direct patients direct in to a clinical pathway.

**Seven-day services**

The emergency department was available for all patients 24 hours a day, 365 days a year. Within the department, there were areas which had times where they were unavailable to patients. The minors’ department was open between 8am and 2am seven days a week.

Patients had timely access to diagnostics such as X-rays and computerised tomography (CT) scans and support services such as pathology and theatres were available 24 hours a day. There was an X-ray department attached to the emergency department.
There was 24-hour access to consultant directed interventions including coronary care services, critical care and emergency general surgery.

Health promotion

Royal Hampshire County Hospital

A range of information was on display throughout the department directing patients to support networks. Staff were observed coaching patients, providing individuals with advice and information on how best to manage specific chronic health conditions.

Basingstoke and North Hampshire Hospital

There was a lack of information within waiting and clinical areas to help support national health promotion initiatives. However, we observed staff providing patients with verbal advice on chronic conditions, smoking cessation and obesity. There was however, limited guidance and information which directed patients and relatives to alternative health services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from April 2017 to February 2018 Mental Capacity Act (MCA) training has been completed by 64.5% of staff within urgent and emergency care trust-wide. Medical/dental staff had a completion rate of 70.0% and nursing staff had 66.1% completion rate. Information submitted by the trust following the inspection indicated a marginally different compliance rate as follows:

Medical/Dental – 68.2%
Nursing – 66.1%

The trust reported that the Deprivation of Liberty training is encompassed in the MCA training modules and is not a separate course. Deprivation of liberty training is not mandatory, although the current training completion rate is 69% trust-wide.

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

Royal Hampshire County Hospital

Nursing staff lacked awareness of their responsibilities under the Mental Capacity Act, with nursing staff telling us that it is the doctors’ responsibility to complete mental capacity assessments.

We reviewed the notes of three patients who had presented with mental health conditions. There was no capacity assessments recorded for any of the three patients. One patient was described as being agitated, chatty and distressed. Their care record stated the plan for the patient, should they abscond, was to be “Brought back by the police”. Because staff had not completed a mental capacity assessment, we could not be assured staff were aware as to whether the patient had the capacity to make a decision to leave the department without receiving care or treatment. We raised this with the nurse in charge who stated the police would be requested to “ask” the patient to return to the ED and that no legal framework would be used to force the patient to return against their will.
Basingstoke and North Hampshire Hospital

We reviewed a total of 25 sets of notes during the inspection. These ranged from notes for children who had attended, patients presenting with mental health conditions, and those conveyed by ambulance. One patient with a diagnosis of schizophrenia had presented to the ED. We noted a mental health risk assessment form (SHREWD) had been completed. The actions listed to reduce the risk of absconding were “place in observable bay”. An entry in the notes reported the patient was “unable to retain information, unsteady on feet, at risk of harm”. The patient was reviewed by a consultant one hour after this entry was made who wrote “Patient deemed to have capacity, if patients wishes to leave, patient is able to make that decision”. The Mental Capacity Act Code of Practice recommends that, in order to assess whether a person has the mental capacity to make a specific decision, the health professional should consider a two-stage test:

“Anyone assessing someone’s capacity to make a decision for themselves should use the two-stage test of capacity.

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn’t matter whether the impairment or disturbance is temporary or permanent.)
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Assessing ability to make a decision

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?”

There was no documentation within the patient record which described how the doctor had reached the decision about the patient having capacity; especially in light of the fact a previous entry had stated the patient was not retaining information. Nursing staff reported they would have expected the doctor to record a mental capacity assessment within the notes however this had not been recorded. We were informed the doctor had consulted with the mental health team before making decision in regards to the patient having capacity and being able to leave the department freely. Again, this discussion had not been documented at the time of the notes review.

At the time of our inspection, there were no patients detained under the Mental Health Act. Staff were generally aware of their responsibilities in relation to patients who may be detained, however they would seek further specialist input from the mental health liaison and crisis teams if required.

Is the service caring?

Compassionate care

Friends and Family test performance

From April 2017 to March 2018, the trust’s urgent and emergency care friends and family test performance (% recommended) was better than the England average with the exception of November 2017, where performance was the same as the England average. There was a downward trend over the reporting period.
In the latest period, March 2018, the trust’s performance was 88.2%, compared to the England average of 84.3%.

**A&E Friends and Family Test Performance - Hampshire Hospitals NHS Foundation Trust**

![Graph showing A&E Friends and Family Test Performance](image)

(Source: NHS England Friends and Family Test)

The trust reports departmental performance against friends and family that includes response rates and the percentage of patients who would and who would not recommend one of four services (Inpatients, ED, Maternity and outpatients). Whilst CQC has presented the data of the department and provided a comparator against the national average, there is no comparison with national performance within the trust board papers and so it is not possible for the board of directors to compare and consider their position (BoD papers 27 July 2018).

The most recent data for June 2018 indicated 87% of patients (responses received from 1,699 patients) would recommend the Trust’s UEC departments whilst 6% would not. There has been a downward trend in the number of patients who would recommend the service to their friends or family since April 2017 however this remains aligned to national trends.

**Royal Hampshire County Hospital**

Staff demonstrated understanding and non-judgemental attitudes towards patients with mental health, learning disability, dementia and autism diagnoses. We saw staff respecting a patients request for sleep despite it being day time, although due to risks they could not close all the curtains around the patients bed they turned the lights off and pulled the curtains at the sides up to provide as much darkness and privacy as possible.

Staff were observed treating patients in a kind and compassionate way. Staff utilised curtains and doors when undertaking physical examinations of patients or when speaking with patients.

We spoke with eight patients who each reported staff had treated them with respect and had protected their privacy and dignity.

**Basingstoke and North Hampshire Hospital**

We observed staff moving patients from ambulance trolleys to hospital trolleys within the rapid assessment area, using pat-slides. Staff did not use screens to help protect the privacy of patients.
Due to the limited space and lack of side rooms, it was possible to hear ambulance staff handing over patients to hospital staff within the rapid assessment area. Conversations were held about patients in sight and hearing of other patients that included medical and social needs of patients.

Patient privacy in the mental health assessment room was compromised due to the use of a two-way mirror in one of the doors. There was no way of stopping people outside the room looking in through the mirrored door panel.

On 11 July 2018 at Basingstoke and North Hampshire Hospital, we observed two separate patients undergo ECGs within the triage room located within the main reception area of the ED. Other patients were present in the waiting area and a failure to close the door directly linked to the waiting area, meant patients could observe individuals undergoing their ECG.

On 11 July 2018, we observed in the triage room located at Basingstoke and North Hampshire Hospital, the computer terminal was unlocked and unattended, with both doors to the room open; the current ED patient list was on display, therefore compromising people’s confidentiality.

During the unannounced inspection of the ED at Basingstoke and North Hampshire Hospital on 17 July 2018, we observed a healthcare assistant undertaking physical observations of patients waiting in the waiting room and also those receiving “Corridor care” in majors. Whilst cubicles were equipped with curtains, staff did not always use them when providing care to patients. This practice did not protect people’s privacy.

Emotional support

We observed specialist nurses providing advice and support to patients on particular pathways, for example, those commencing treatment on the coronary care pathway. Patients reported they had been well informed of their treatment plan and had received good support from the specialist nurses.

Due to the busy nature of the department at Basingstoke and North Hampshire Hospital, we noted two occasions when an elderly patient and a patient with a chronic mental health condition had asked for support with using the toilet. Whilst staff had acknowledged both individuals, it took forty-five minutes and forty minutes respectively for such support to be afforded to the individuals.

Understanding and involvement of patients and those close to them

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 22 of the 24 questions relevant to caring. The two remaining questions (questions 26 and 38) were better than other trusts.

<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>3.5</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</td>
<td>8.8</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</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>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and</td>
<td>9.0</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>nurses examining and treating you?</td>
<td></td>
<td>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>9.3</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>8.2</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>8.7</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>7.8</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>9.1</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>8.2</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>9.2</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>7.7</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>7.3</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>8.9</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.7</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>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q36. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.7</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.1</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>5.9</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>5.9</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>6.6</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>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey – September 2016)

Royal Hampshire County Hospital

Staff had access to communication aids to help patients become partners in their care and treatment. Staff explained they are able to use picture boards and written information to support patients.
Basingstoke and North Hampshire Hospital

We spent time speaking with patients waiting either within the waiting room, or within the major’s area. There was a general theme that patients told us they were not really sure what was going to happen next or where they were on their treatment pathway. However, other patients reported they had received sufficient information. They had been given the reason for delays and had received apologies.

Patients told us they felt comfortable in asking staff to explain things again if they had not understood what they had been told the first time round.

We observed staff communicating with patients in a way that they understood and using language they understood. For example, we observed staff talking with a confused elderly patient in a way that was not condescending or patronising. The staff member repeated a number of times the treatment plan for the patient and apologised for the delays they had experienced.

Is the service responsive?

Service delivery to meet the needs of local people

Royal Hampshire County Hospital

The department did not currently meet all the standards of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (2018). There was an area adjacent to the main waiting room designated for children to wait. This area was separated from the main adult waiting area by a set of doors (providing an audio and visual barrier) however children still had to enter through the same entrance as adult patients and then walk past them to get to the designated children’s waiting room. Signs were present in the waiting room advising the parents of children to alert staff if they felt their child was deteriorating. The department had also attempted to designate a cubicle in majors and a bay in the resus area for children, however during our inspection, children present in the department were not always placed in these areas due to them being occupied by adults.

There was limited quiet space within the main waiting room to accommodate patients who were anxious or who required a safe space to wait. However, we noted the waiting room was clean, resourced with patient information and was rarely seen to be over half full.

Improvement works had been undertaken to extend the minor’s treatment area in order that performance for such patients could be improved, therefore enhancing the overall experience for patients. Clinical areas were clean, clutter free, calm and well organised, if not a little dated in some areas. A centrally located nursing staff afforded good oversight of each of the clinical cubicles within majors.

Basingstoke and North Hampshire Hospital

The patient waiting area was not sufficiently large to accommodate the current flow of patients. Due to the high level of attendances, mixing of minors, majors and GP pathway patients, the waiting room was observed to be overcrowded at times. Patients presenting on foot were seen to be queuing outside the waiting area during peak periods. Whilst these queues were infrequent and moved at pace, there was insufficient provision of seating to allow those acutely unwell to rest whilst waiting to be seen by the streaming nurse. Patients who presented to the streaming nurse were required to provide a summary of their health complaint. This could be heard by other
patients waiting in the queue and those patients sitting near to the streaming nurse’s station that was located next to the reception area.

A quiet area was available in the department directly next to the children’s waiting area where patients could wait if they found busy environments distressing. However, this was also used as a thoroughfare to the major’s and, at times, a safe zone for those who presented with challenging behaviours. The team acknowledged that this was not an ideal location for such patients however, there was limited scope within the footprint of the emergency department for alternative arrangements to be made.

The department did not currently meet all the standards of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (2018). There was an area adjacent to the main waiting room designated for children to wait. This area was separated from the main adult waiting area by a set of doors (providing an audio and visual barrier) however children still had to enter through the same entrance as adult patients and then walk past them to get to the designated children’s waiting room. This area could also not be monitored by the streaming nurse; instead, there were sign advising the parents of the children to alert staff if they felt their child was deteriorating. The department had also attempted to designate a cubicle in majors and a bay in the resus area for children, however during our inspection, children present in the department were not always placed in these areas due to them being occupied by adults. A dedicated clinical assessment room was co-located within the children’s waiting area which afforded a level of adaptation in order so it was child friendly. However, during an unannounced inspection we found the area was occupied with an adult who was awaiting treatment.

The mental health assessment room did not have adjustable lighting; the room had natural light from windows just below the ceiling that could not be covered to create a dark room and could not be opened.

**Meeting people’s individual needs**

**Emergency Department Survey 2016**

The trust scored about the same 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>6.7</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>7.0</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>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

**Royal Hampshire County Hospital**

The trust was not complying with the requirements of the accessible information standards. There was no hearing loop installed within the department. A hearing loop system is a sound system that boosts the signal in a person’s hearing aid, therefore helping someone with a hearing impairment to focus on the sounds which are most important, for example, staff from the department talking to them. Staff also told us there was no way of identifying and flagging patients who required additional support in relation to their information and communication.
needs. Whilst staffs showed us various picture books as a means of communicating with those with learning disabilities for example, they reported they would more routinely rely on information from relatives and carers.

Chaplaincy services were available at this location 8am-10pm seven days a week. Outside of these hours, the chaplaincy service provided an on-call service. The hospital chapel/faith rooms were available to patients and staff at all times. The core team of chaplains were of Church of England and Roman Catholic denominations; however, all religious needs could be met if requested.

Staff told us and we saw there were resources available to meet the individual needs of patients living with dementia which included a resource trolley located in the major’s area of the department. There were no other resources or adaptations in the environment to meet the individual needs of a patient living with dementia.

Basingstoke and North Hampshire Hospital

Whilst the trust subscribed to a telephone interpreting service, we found that this was not routinely used by staff despite there being a need for such a service. Reception and nursing staff reported they would communicate with non-English speaking patients by writing down simple instructions in English; this was a flawed concept as the onus was on the non-English speaking patient to be able to read English as compared to speaking English. Staff also reported they would use other members of staff or family members of patients to translate should the need arise. There was no immediate provision for health promotion documentation, or other information leaflets to be handed to patients in languages other than English. All signage in the department was in English and was often confusing to understand.

The trust was not complying with the requirements of the accessible information standards. There was no hearing loop installed within the department. A hearing loop system is a sound system that boosts the signal in a person’s hearing aid, therefore helping someone with a hearing impairment to focus on the sounds which are most important, for example, staff from the department talking to them. Staff also told us there was no way of identifying and flagging patients who required additional support in relation to their information and communication needs. Staff did not utilise picture books as a means of communicating with those with learning disabilities for example.

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Staff told us and we saw there were resources available to meet the individual needs of patients living with dementia which included a resource trolley located in the major’s area of the department. There were no other resources or adaptations in the environment to meet the individual needs of a patient living with dementia.

Access and flow

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour.
From April 2017 to March 2018, the trust met the standard for six months over the 12 month period. No data was available for October 2017.

In the latest period, March 2018, the median time to treatment was 58 minutes compared to the England average of 64 minutes.

**Ambulance – Time to treatment from March 2017 to February 2018 at Hampshire Hospitals NHS Foundation Trust**

![Graph showing time to treatment from March 2017 to February 2018 for Hampshire Hospitals NHS Foundation Trust.](Source: NHS Digital - A&E quality indicators)

**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 ED.

The trust met the standard once in May 2017 and breached the standard 11 times for the remainder of the reporting period from June 2017 to April 2018.

From May 2017 to December 2017 performance against this metric showed a trend of decline and fell below the England average from September 2017, before improving for the remaining period up to April 2018, where it was slightly above the England average.

**Four hour target performance - Hampshire Hospitals NHS Foundation Trust**

![Graph showing four hour target performance from May 2017 to April 2018 for Hampshire Hospitals NHS Foundation Trust.](Source: NHS England - A&E Waiting times)
The trust did not meet its agreed four-hour trajectory of 93% for quarter 1 of 2018/2019. Year to date performance was reported as 86.9%. Performance for June 2018 was reported as 85.6% (Trust board papers 27 July 2018).

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**

From May 2017 to April 2018 Hampshire Hospitals NHS Foundation Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently worse than the England average. Performance against this metric showed a trend of decline from May 2017 to December 2017 before improving in January 2018 and April 2018.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Hampshire Hospitals NHS Foundation Trust**

The below table shows the number of patients waiting between 4 and 12 hours from the decision to admit until being admitted:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-17</td>
<td>311</td>
</tr>
<tr>
<td>Jun-17</td>
<td>478</td>
</tr>
<tr>
<td>Jul-17</td>
<td>340</td>
</tr>
<tr>
<td>Aug-17</td>
<td>505</td>
</tr>
<tr>
<td>Sep-17</td>
<td>676</td>
</tr>
<tr>
<td>Oct-17</td>
<td>651</td>
</tr>
<tr>
<td>Nov-17</td>
<td>979</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1,258</td>
</tr>
<tr>
<td>Jan-18</td>
<td>809</td>
</tr>
<tr>
<td>Feb-18</td>
<td>968</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1,058</td>
</tr>
<tr>
<td>Apr-18</td>
<td>554</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E SitReps).
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from May 2017 and April 2018, one patient in September 2017, one patient in February 2018 and two patients in March 2018 waited more than 12 hours from the decision to admit until being admitted. The trust reported that three of these patients were awaiting placement within a specialist mental health service as compared to waiting for a bed within Basingstoke and North Hampshire Hospital.

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

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From April 2017 to March 2018 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was consistently better than the England average.

However, from October 2017 to February 2018 performance against this metric showed 0% of patients leaving the trust’s urgent and emergency care services before being seen for treatment, suggesting a data submission issue.

In the latest period, March 2018 performance against this metric was 0.8% compared to 3.3% England average.

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

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

Median total time in A&E per patient (all patients)

From April 2017 to September 2018 the trust’s monthly median total time in A&E for all patients ranged from 141-150 minutes and fluctuated around the England average. No data was available for October 2017. From November 2017 to March 2018, performance against this metric was better than the England average.
In the latest period, March 2018 the trust’s monthly medial total time in A&E for all patients was 170 minutes compared to the England average of 160 minutes.

**Median total time in A&E per patient - Hampshire Hospitals NHS Foundation Trust**

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

**Learning from complaints and concerns**

**Summary of complaints**

From March 2017 to February 2018 there were 88 complaints about urgent and emergency care trust-wide. The trust took an average of 24.9 days to investigate and close complaints.

The most prevalent complaint themes were clinical treatment with 31 (35.2%), patient care with 18 (20.5%) and values and behaviour with 14 complaints (15.9%).

Thirty-one of the 88 complaints (35.2%) related to urgent and emergency care at Royal Hampshire County Hospital.

Basingstoke and North Hampshire Hospital received the majority of the complaints about urgent and emergency care with 55 (62.5%).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

**Is the service well-led?**

**Leadership**

**Royal Hampshire County Hospital**

The emergency department fell under the auspices of the medicine division. The service was led by a clinical lead and operational service manager (OSM). A substantive matron was in post reporting directly to the operational service manager.
Staff reported the nursing and operational leadership as being visible within the department. The matron undertook two clinical shifts each week, working alongside nurses and other health professionals. The operational service manager was present in the department and was reported as the engineer for developing the service, including the delivery of the new minor’s area. There was some reported concern regarding the structure of the team in that there was insufficient consideration given to the view of the nursing workforce, with operational staff directing the agenda of the service.

Staff reported conflict between the views of operational staff and that of those providing clinical care. A number of staff raised concerns regarding changes to practice, including the extending of the ENP service to 02:00 in order that it was aligned to the service delivered at Basingstoke and North Hampshire Hospital. Staff reported they had raised concerns regarding the change to the service but that those concerns had not been sufficiently considered. This was reported to have impacted on the morale of the department. Staff reported feeling frustrated by the opposing agendas of finance (and performance) versus quality. Staff were seeking a steer from the department leads in ensuring equal focus was afforded to both agendas however this had been lacking.

Staff reported a lack of understanding as to who was accountable for the department, especially in regards to elements related to quality. Some considered this to solely be the responsibility of the matron, whilst others considered the clinical director to be accountable. A review of governance meetings suggested a significant lack of nursing input into the agenda and discussions, with attendance predominantly recorded as being representatives from the medical workforce.

**Basingstoke and North Hampshire Hospital**

The emergency department fell under the auspices of the medicine division. The service was led by a clinical lead who was supported by an operational service manager (OSM). A matron who was newly appointed, having been in post for only two days prior to our inspection, reported directly to the OSM.

It was apparent through conversations with staff across all grades and professions that nursing leadership had been inadequate prior to the appointment of a new matron. It was clear through a review of nursing audits and through discussions with staff, that quality of care had not been a significant priority for the department. There was emphasis on improving the performance and flow of the department with little attention paid to the impact this may have had on quality and experience. There had existed a lack of skills and competence within the leadership tier to consider all elements of intelligence that was routinely gathered to help assess the quality of the service being provided. For example, consideration of incidents, complaints, AuditR outcomes, friends and family trend analysis were all elements which, when reviewed, were suggestive of issues concerning the quality of the service being provided. These elements were not considered during governance meetings which were poorly attended and rarely multi-disciplinary. Clinical staff such as senior nurses were not sighted on, or engaged in the quality agenda in a meaningful way due to the operational pressures of the department.

During our time, we observed the leadership of the department during peak time. The performance of the department was multi-factorial; however, it was apparent that when there was poor clinical leadership, the department experienced a drop in performance. A lack of visible senior clinical leadership meant standards of care could not be assured. For example, poor compliance with the completion of early warning tools; lack of risk assessments; poor use of clinical spaces etc, were all linked to a lack of clinical leadership. However, during the inspection, we observed senior nursing staff working hard to ensure patient and staff needs were being met. Whilst this was a
reactive approach of the senior nursing team, it was demonstrable of a department under immense pressure.

Vision and strategy
There was no formalised vision or strategy for emergency care within Hampshire Hospital NHS Trust at the time of the inspection. There had been significant focus placed on the commissioning of a new hyper-acute hospital within the Basingstoke vicinity. Staff confirmed they had spent a significant amount of time designing the new emergency department. However, a decision in 2017 meant the new build would not progress. Staff acknowledged they had not considered a “Plan B” as all triggers were suggestive of an agreement to the progressing of the new build. This had resulted in an element of planning blight and future proofing for emergency services.

Board papers for July 2018 acknowledged the difficulties of sustaining two emergency services across the trust. In part, this was linked to the significant challenges face by the trust in regards to the recruitment and retention of middle-grade doctors. A decision to invest in additional consultants demonstrated a commitment of the trust to continue to deliver emergency care across two acute locations. Staff acknowledged the challenges they faced with year on year increases in attendances to the emergency department, caused in part, by an increase in the population of Basingstoke and surrounding areas. There was a general consensus the emergency department was not fit for purpose due to its limited size and current design. However, there was currently no strategy that detailed what these services would look like, nor how they would be designed within the current footprint of the hospital.

Culture
There was a general consensus amongst the staff we spoke with that morale within the department was good, despite the uncertainties of the future of the unit. However, the trust participated in the 2017 NHS staff survey and each division was provided a breakdown in order action plans could be developed to address local issues or concerns. For RHCH unscheduled care, the overall response rate was 29% (53 of a possible 179) which was significantly worse than the trust average response rate of 43.3%. One member of the senior team said they were concerned by this poor response rate, as it was difficult to capture the view of the representative workforce. They were concerned more by what was not said as to the comments and responses provided.

Royal Hampshire County Hospital
Unscheduled care responses were better in five questions:

- Know how to report unsafe clinical practice
- Not experienced physical violence from managers
- Had training, learning or development in the last 12 months)
- Patient/service user feedback collected within directorate/department
- Receive regular updates on patient/service user feedback in my directorate/department

Unscheduled care responses were significantly worse in 21 questions:

- Often/always look forward to going to work
- Able to do my job to a standard I am pleased with
- Able to make improvements happen in my area of work
- Able to meet conflicting demands on my time at work
- Have adequate materials, supplies and equipment to do my work
- Enough staff at organisation to do my job properly
- Team members often meet to discuss the team's effectiveness
- Satisfied with extent organisation values my work
- Satisfied with level of pay
- Satisfied with quality of care I give to patients/service users
- Able to provide the care I aspire to
- Immediate manager asks for my opinion before making decisions that affect my work
- Immediate manager values my work
- Senior managers try to involve staff in important decisions
- Organisation definitely takes positive action on health and well-being
- Not felt unwell due to work related stress in last 12 months
- Don't work any additional paid hours per week for this organisation, over and above contracted hours
- Not experienced physical violence from patients/service users, their relatives or other members of the public
- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
- Appraisal/performance review: organisational values definitely discussed
- Care of patients/service users is organisation's top priority

**Basingstoke and North Hampshire Hospital**

Unscheduled care responses were better in five questions:
- Time often/always passes quickly when I am working (90% vs 79%)
- I know who my senior managers are (93% vs 85%)
- Organisation takes action to ensure errors are not repeated (89% vs 72%)
- Staff given feedback about changes made in response to reported errors (78% vs 61%)
- Patient/service user feedback collected within directorate/department (97% vs 91%)

Unscheduled care performed worse than the trust average in five questions:
- Don't work any additional paid hours per week for this organisation, over and above contracted hours (38% vs 63%)
- Not experienced physical violence from patients/service users, their relatives or other members of the public (59% vs 86%)
• Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public (61% vs 77%)
• Had appraisal/KSF review in last 12 months (59% vs 78%)

With the appointment of a new matron, the local leadership team were committed to addressing concerns within the department. This included improving the morale of the team, stabilising the workforce, addressing the basics in regards to nursing care and improving the overall experience for patients. This approach was acknowledged and well received by those members of staff we spoke with. There was a commitment from the leadership team to resolve long standing cultural challenges within the department. The matron was keen to enhance the concept of professional accountability and would look to support their direct line reports who were involved in people and performance management challenges.

Governance

We asked the trust to provide us with minutes of clinical governance meetings held within the department. We received a range of documents including one set of minutes for a clinical governance meeting held on 19 June 2017. We also received copies of morbidity and mortality governance meetings for March, April, May and June 2018. It was not clear from the minutes whether additional meetings were held within the department in which incidents, AuditR, national audit outcomes, patient experience, thematic reviews, performance and wider quality matters were discussed. Minutes of the above meetings were reviewed and considered to be poor in content. Meeting minutes were divided into mortality reviews, audit presentations (by exception), complaints /governance and any of business. There was no formalised action plan which tracked actions and therefore it was not possible to determine whether actions had been completed. Attendance at meetings was limited with only five in attendance for one meeting held on 17 April 2018. Other meetings were only attended by between six and eight people.

The OSM produced a monthly scorecard which included, on one page, a range of information. Information was reported against quality, performance, activity and expenditure, workforce and risk. The information was limited and not sufficiently detailed.

Royal Hampshire County Hospital

For example, in April 2018, the scorecard reports:

• No reportable Clostridium difficile
• No MRSA bacteraemia
• Zero pressure ulcers
• 2 falls (all no harm)
• 2 medication errors, all no harm
• 4 complaints
• 17 thankyous
• 38 open incidents
• FFT response rate of 20%
• Appraisal rate of 61%.
In May 2018, the scorecard reports

- No reportable Clostridium difficile
- No MRSA bacteraemia
- Zero pressure ulcers
- 7 falls (all no harm)
- 10 medication errors, all no harm
- 3 complaints
- 10 thankyous
- 42 open incidents
- FFT response rate of 21%
- Appraisal rate of 72%.

There was no scope to consider any of the information in greater detail. There was no reference made to the unscheduled care scorecard within the governance meeting and so we were not assured sufficient focus was placed on considering quality in any significant detail. This was consistent with the result of conversations with staff. Both band six and band seven nursing staff had a high-level appreciation of quality issues within the department, however they lacked any significant understanding of the work underpinning any improvement plans.

We asked the trust for a range of information during and after the inspection. One such request related to confirmation of the number of staff who had completed a competency framework which encompassed the care of the sick child competencies. The trust was not able to provide this information because, at the time of the inspection, there was no centrally held record which recorded such information. Following our inspection, we issued a number of conditions which required the trust to take specific action. One such action was to ensure competent staff were deployed at all times. In order to do this, the trust undertook a programme of work to establish the competencies of each member of staff working in the emergency department.

The trust facilitates Governor Visits to support the governance function of the organisation. The purpose of the visits was to increase the awareness of the Health and Social Care Act Fundamental Standards and to provide Governors an opportunity to meet with patients and staff and to identify areas of good practice. There had been no Governor visits to the Emergency Department between July 2017 and March 2018.

*Council of Governor Meeting Minutes (16 January 2018/17 April 2018)*

**Management of risk, issues and performance**

**Royal Hampshire County Hospital**

Risk management was poorly understood by those working in the department. There was a lack of appreciation of national guidance around matters such as environmental risk assessments for example. We asked staff to describe the risks which were currently the most important to the department. Staff consistently reported the four-hour target, staffing and the future of the unit as being the three most significant risks. A review of the departmental risk register confirmed environmental factors such as ligature points was not an identified risk for the department. Further,
the two emergency departments within the trust worked in such silo’s that little thought had been
given to sharing lessons learnt from the recent design of the “Place of safety” room which had
recently been completed at Basingstoke and North Hampshire Hospital. Further to this, the silo
working meant staff were not sighted on incidents occurring across the two sites. This
demonstrated a significantly isolated and inward team, with the only common denominator being
the clinical director.

Compliance with national guidance in regards to environmental adaptations for children accessing
emergency care services within the district general setting was not considered or listed as a risk.
The poor clinical oversight and supervision of the children’s waiting area had also not been
identified as a risk. This was despite the trust receiving feedback from a patient who raised
concerns regarding the lack of supervision of the waiting area.

Whilst performance against the four-hour target was listed as a trust wide risk, the risk was not
recorded on the unscheduled care risk register as a risk in its own right. Further, poor compliance
with AuditR topics was not identified as a risk, nor was compliance with trust protocols such as the
deteriorating patient.

Audit participation was low in some areas. For example, the department had not participated in a
number of RCEM audits in 2017. The senior team told us this was partly because of the low
numbers of substantively employed medical staff within the department. When audits were
conducted in the department, there was not always evidence of action plans being developed to
identify where work was going to be focused to improve the outcomes. An example of this was
identified in the dislocated shoulder audit in which it was recognised pain assessment and record
keeping was poor. Whilst an action to address this had been included in the minutes of a
governance meeting, our observations and review of records was that practice had not
dramatically improved in regards to the recording and assessment of pain in patients.

Basingstoke and North Hampshire Hospital

Risk management was poorly understood by those working in the department. There was a lack of
appreciation of national guidance around matters such as environmental risk assessments for
example. We asked staff to describe the risks which were currently the most important to the
department. Staff consistently reported the four-hour target, staffing and trolley waits in the AAU
as being the three most significant risks. A review of the departmental risk register confirmed
environmental factors such as ligature points was not an identified risk for the department. We
heard of two events in which violent patients had destroyed furniture within the relatives’ room in
the majors department. The risk register captured a risk related to agitated or distressed patients
and/or relatives. A narrative within the risk identified that agitated individuals posed a risk to the
environment and equipment. Mitigations to managing the risk included “Security doors installed to
ensure safe lock down of areas. Assessment nurse/ Triage nurse updates patients regarding
waiting times. Conflict Resolution training to be completed. Safeguarding adults and children
training completed by all staff. Access to security back up. Designated space for vulnerable
patients.” There was no consideration to making appropriate amendments to the environment or
for securing heavy furniture to fixed structures so they could not be used as projectile items.
Further compliance against safeguarding adults and children was seen to be significantly below
the trust average and therefore raised concerns over the validity of the mitigations being offered to
control the risk.

Compliance with national guidance in regards to environmental adaptations for children accessing
emergency care services within the district general setting was not considered or listed as a risk.
The poor clinical oversight and supervision of the children’s waiting area had also not been
identified as a risk. This was despite the trust receiving feedback from a patient who raised concerns regarding the lack of supervision of the waiting area.

Further, poor compliance with AuditR topics was not identified as a risk on the local risk register, nor was compliance with trust protocols such as the deteriorating patient.

Audit participation was low in some areas. For example, the department had not participated in a number of RCEM audits in 2017. The senior team told us this was partly because of the low numbers of substantively employed medical staff within the department. When audits were conducted in the department, there was not always evidence of action plans being developed to identify where work was going to be focused to improve the outcomes. An example of this was identified in the dislocated shoulder audit in which it was recognised pain assessment and record keeping was poor. Whilst an action to address this had been included in the minutes of a governance meeting, our observations and review of records was that practice had not dramatically improved in regards to the recording and assessment of pain in patients.

**Information management**

The trust had a number of information management technologies in use at the time of the inspection. The ED opted to use a system which was not connected to any other information system in the trust. Therefore, there was a requirement for staff to copy patient records before a patient was transferred to a clinical ward. This was considered burdensome by staff as it increased the time it took to transfer patients from the emergency department.

At Basingstoke and North Hampshire Hospital, we noted on multiple occasions during the inspection, unlocked computer screens in and around the department. This meant patients and visitors could access a list of patients currently within the department.

**Engagement**

The department tried to engage the public with their views in the department. We observed a ‘you said, we did’ board within the department which was displayed in the waiting area. This board was established following CQC’s initial announced inspections in which we opted to use our enforcement powers to encourage the trust to make improvements. Examples of issues raised included our concerns regarding the children’s waiting room, poor compliance with observation tools and a lack of competent and skilled staff. The trust was candid regarding the action they took and continued to take to address the concerns we raised.

At the time of our inspection, we did not see any specific engagement arrangements in place to receive feedback with patients who had mental health and emotional well-being concerns, or from children. This was despite there being a year-on-year increase in the number of patients presenting with such conditions. Further, there was no information displayed which described how patients and relatives could engage with the team to help influence the service further.

**Learning, continuous improvement and innovation**

Despite an initial lack of action to resolve long-standing issues such as the provision of services for children, the trust responded quickly following our inspection to try to address some of the issues we raised. The local team relocated the children’s waiting area so that it was co-located in the main waiting area. Whilst there was still no direct clinical supervision, the area was in close proximity to the streaming nurse. In addition, the team had introduced hourly rounding within the
children’s waiting area during which time observations and PEWS scores were calculated to enable staff to identify deteriorating children.

The introduction of RemED and ambulance linked clinical pathways was considered to be a positive move to addressing performance issues within the department. Whilst there had been limited data available at the time of inspection to determine the effectiveness of RemED, it was reported the programme was having a positive impact on reducing the number of patients waiting to access emergency care.

However, there existed a lack of appetite to consider learning from complaints, incidents and audit activity to improve the overall quality of care provided within the department. During peak times, the department was described as being “Under siege”. Staff felt that a lack of support from specialities contributed to a feeling of failure amongst ED staff, especially when performance was significantly impacted. There was an attitude amongst clinical leaders within the ED to try to resolve specific issues personally rather than use agreed escalation protocols. We considered the impact of this was a lack of system wide awareness of the challenges faced by the ED and therefore brought in to question the long-term viability of initiatives such as RemED.
The medical care service at the trust provides care and treatment for 10 specialties: cardiology, diabetes and endocrinology, elderly care and stroke, gastroenterology, endoscopy, respiratory, neurology and rheumatology.

(Source: Routine Provider Information Request – Context Acute)

There are 454 medical inpatient beds located across three sites and 20 wards/units. A ward breakdown by site can be viewed below:

**Basingstoke and North Hampshire Hospital:**

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Number of beds</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>22</td>
<td>Gastroenterology and acute general medicine</td>
</tr>
<tr>
<td>E2</td>
<td>24</td>
<td>General medicine</td>
</tr>
<tr>
<td>E3</td>
<td>28</td>
<td>Respiratory and acute general medicine</td>
</tr>
<tr>
<td>E4</td>
<td>25</td>
<td>Diabetes, endocrinology and acute general medicine</td>
</tr>
<tr>
<td>F1</td>
<td>22</td>
<td>Acute elderly care</td>
</tr>
<tr>
<td>F2</td>
<td>18</td>
<td>Acute elderly care</td>
</tr>
<tr>
<td>F3</td>
<td>14</td>
<td>Acute elderly care</td>
</tr>
<tr>
<td>Cardiac/CCU</td>
<td>27</td>
<td>Inpatient cardiology</td>
</tr>
<tr>
<td>Isolation Ward</td>
<td>7</td>
<td>General medicine</td>
</tr>
<tr>
<td>Lyford Unit</td>
<td>4</td>
<td>Specialty specific day cases and infusions</td>
</tr>
<tr>
<td>Overton Ward</td>
<td>25</td>
<td>Non-acute rehabilitation</td>
</tr>
<tr>
<td>Acute Assessment unit (AA)</td>
<td>14 beds 9 trolleys</td>
<td>Acute medical and fraility unit</td>
</tr>
</tbody>
</table>

**Total** | **230 beds and 9 trolleys**

**Royal Hampshire County Hospital:**

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Number of beds</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarke</td>
<td>24</td>
<td>Inpatient cardiology and stroke</td>
</tr>
<tr>
<td>Clifton</td>
<td>26</td>
<td>Acute elderly care</td>
</tr>
<tr>
<td>Freshfield</td>
<td>26</td>
<td>Delayed transfer of care (DTOC) ward</td>
</tr>
<tr>
<td>McGill</td>
<td>40</td>
<td>Ambulatory care, acute medical and fraility unit</td>
</tr>
<tr>
<td>Shawford</td>
<td>27</td>
<td>Respiratory and acute general medicine</td>
</tr>
<tr>
<td>Twyford</td>
<td>24</td>
<td>Hyper acute stroke unit</td>
</tr>
<tr>
<td>Victoria</td>
<td>27</td>
<td>Gastroenterology and acute general medicine</td>
</tr>
<tr>
<td>Wykeham</td>
<td>22</td>
<td>Acute elderly care</td>
</tr>
</tbody>
</table>

**Total** | **216**

**Andover War Memorial Hospital:**
<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Number of beds</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingfisher</td>
<td>22</td>
<td>Rehabilitation ward</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Sites Acute)

Andover War Memorial Hospital had a day surgery unit which included an endoscopy service.

The trust had 39,754 medical admissions from February 2017 to January 2018. Emergency admissions accounted for 19,825 (49.9%), 353 (0.9%) were elective, and the remaining 19,576 (49.2%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology: 14,645
- General medicine: 13,989
- Cardiology: 2,717

(Source: Hospital Episode Statistics)

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

Trust wide mandatory training completion rates

The trust set a target of 80% for completion of mandatory training, with the exception of information governance module which had a target of 95%. The trust did not provide targets for immediate life support and medicine management training modules which were part of mandatory training for clinical staff.

A breakdown of compliance for mandatory courses from April 2017 to February 2018 for medical/dental and nursing staff in medicine is shown below:

Trust wide Mandatory Training Completion by module – Medical and Dental Staff
The trust was not meeting their mandatory training targets for medical staff for the 10 mandatory training modules shown above. Of the modules where a target was set, dementia training module had the lowest completion rate with 12.7%. Of the modules where a target was not provided, medicine management and immediate life support training modules had low completion rates of 8.7% and 8.3% respectively.

**Trust wide Mandatory Training Completion by module – Nursing Staff**

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>436</td>
<td>478</td>
<td>91.2%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Counter Fraud</td>
<td>428</td>
<td>478</td>
<td>89.5%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>406</td>
<td>478</td>
<td>84.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>384</td>
<td>478</td>
<td>80.3%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire</td>
<td>374</td>
<td>478</td>
<td>78.2%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>373</td>
<td>478</td>
<td>78.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>348</td>
<td>478</td>
<td>72.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control</td>
<td>345</td>
<td>478</td>
<td>72.2%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>328</td>
<td>474</td>
<td>69.2%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>301</td>
<td>478</td>
<td>63.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine Management</td>
<td>181</td>
<td>478</td>
<td>37.9%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>42</td>
<td>474</td>
<td>8.9%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,946</strong></td>
<td><strong>5,728</strong></td>
<td><strong>68.9%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust target was met for four of the 10 mandatory training modules shown above for nursing staff. Of the modules where a target was set, dementia training module had the lowest completion rate with 63%. Of the modules where a target was not set, medicine management and immediate life support training modules had low completion rates of 37.9% and 8.9% respectively.

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

**Andover War Memorial Hospital**

Compliance with mandatory training was below the trust target for all ten mandatory modules for medical staff and below the target for six out of ten modules for nursing staff.

Staff we spoke with told us they had enough time to complete mandatory training courses. Mandatory training compliance reports were displayed in staff rooms to remind staff to complete all mandatory training courses.

**Basingstoke and North Hampshire Hospital**

Compliance with mandatory training was below the trust target for all ten mandatory modules for medical staff and below the target for six out of ten modules for nursing staff.

Staff we spoke with told us they had enough time to complete mandatory training courses. Staff mandatory training compliance reports were displayed in staff rooms to remind staff to complete...
all mandatory training courses.

A matron we spoke with told us there had been problems with the availability of basic life support training courses across the trust but we were told this situation was now improving.

On the acute assessment unit, the matron had calculated the time for completion of all mandatory training as 11.5 hours so any staff undertaking training outside of their working hours would get the time back.

We saw from the E1 ward meeting minutes for March 2018 staff were encouraged to check their mandatory training records every month.

Royal Hampshire County Hospital

Compliance with mandatory training was below the trust target for all ten mandatory modules for medical staff and below the target for six out of ten modules for nursing staff. Staff we spoke with told us they had enough time to complete mandatory training courses. Staff mandatory training compliance reports were displayed in staff rooms to remind staff to complete all mandatory training courses.

Divisional governance leads shared monthly training reports with the clinical matrons.

Safeguarding

Trust wide

We reviewed the trust safeguarding adults’ policy and saw it was up to date, due for review in August 2019. The policy outlined staff responsibilities and the reporting process for a safeguarding concern. The policy outlined staff duties in relation to reporting female genital mutilation (FGM)

Trust wide Safeguarding training completion rates

The trust set a target of 80% for completion of safeguarding training.

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

Safeguarding Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children</td>
<td>115</td>
<td>173</td>
<td>66.5%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>93</td>
<td>173</td>
<td>53.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208</strong></td>
<td><strong>346</strong></td>
<td><strong>60.0%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 80% target was not met for either safeguarding training modules for which medical staff in medicine were eligible. Safeguarding adults had the lowest completion rate with 53.8%. Safeguarding children’s training compliance was 66%.

Safeguarding Training Completion by module – Nursing Staff

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>411</td>
<td>478</td>
<td>86.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>408</td>
<td>478</td>
<td>85.4%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>819</strong></td>
<td><strong>956</strong></td>
<td><strong>85.7%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The 80% target was met for both safeguarding adults and safeguarding children training modules for which nursing staff in medicine were eligible to complete.

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

Andover War Memorial Hospital

The service did not give safeguarding training sufficient priority. The trust safeguarding training target was only 80%. Medical staff’s compliance with safeguarding training on how to recognise and report abuse was below the trust target for adults and children modules.

Nursing staff understood and followed the process to report safeguarding concerns. Staff we spoke with could recognise the signs of abuse and were aware of the different forms of abuse. Staff gave examples of how they would spot a safeguarding concern such as if a patient was anxious and withdrawn before or after a relative visited. Staff knew how to access support from the trust’s safeguarding lead or clinical matron.

Following our inspection, the trust provided updated safeguarding children level 2 and level 3 training compliance data broken down by site as of 31 May 2018. Data showed 84% staff were trained to safeguarding children level 2 and 83% were trained to safeguarding children level 3. This met the trust target of 80%.

Basingstoke and North Hampshire Hospital

The service did not give safeguarding training sufficient priority. The trust safeguarding training target was only 80%. Medical staff’s compliance with safeguarding training on how to recognise and report abuse was below the trust target for adults and children modules.

Nursing staff understood and followed the process to report safeguarding concerns. Staff we spoke with showed an awareness of the signs of abuse and understood the safeguarding reporting process. Staff told us they would escalate safeguarding concerns to the nurse in charge or clinical matron and speak with the safeguarding lead if they needed advice. Staff we spoke with said they would report safeguarding concerns through the electronic reporting system.

Staff we spoke with knew how to contact the trust’s safeguarding leads for advice and told us they were supportive.

On the acute assessment unit, we saw staff had access to a folder with contact details and the safeguarding referral process to follow.

Following the inspection, the trust provided updated safeguarding children level 2 and level 3 training compliance data broken down by site as of 31 May 2018. Data showed 78% staff were trained to safeguarding children level 2 and 43% were trained to safeguarding children level 3. This did not meet the trust target of 80%.

Royal Hampshire County Hospital

The service did not give safeguarding training sufficient priority. The trust safeguarding training target was only 80%. Medical staff’s compliance with safeguarding training on how to recognise and report abuse was below the trust target for adults and children modules.

Nursing staff we spoke with showed an awareness of the signs of abuse and understood the safeguarding reporting process. Staff told us they would escalate safeguarding concerns to the
nurse in charge or clinical matron and speak with the safeguarding lead if they needed advice. Staff we spoke with said they would report safeguarding concerns through the electronic reporting system.

Staff we spoke with knew how to contact the trust’s safeguarding leads for advice and told us they were supportive.

Following our inspection, the trust provided updated safeguarding children level 2 and level 3 training compliance data broken down by site as of 31 May 2018. Data showed 83% staff were trained to safeguarding children level 2 and 38% were trained to safeguarding children level 3. This did not meet the trust target of 80%.

Cleanliness, infection control and hygiene

Trust wide mandatory training data for infection prevention and control

Compliance with infection control mandatory training April 2017 to February 2018 for medical/dental and nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental staff</td>
<td>Infection Control</td>
<td>105</td>
<td>173</td>
<td>60.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>Infection Control</td>
<td>345</td>
<td>478</td>
<td>72.2%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

An infection prevention control report was presented to the trust board twice a year. We reviewed infection prevention and control report presented to the board in November 2017 and found the trust set a target of no more than 34 cases of _clostridium difficile_ (C. Diff) in the year April 2017 – March 2018. As of the end of October 2017 there had been 16 cases of reportable hospital acquired _clostridium difficile_ and 29 non-reportable cases. The hospital had declared that there had been no cases of acquired MRSA bacteraemia from April 2017 – March 2018. There were eight cases of Methicillin-sensitive staphylococcus aureus (MSSA) bacteraemia between April and October 2017.

Andover War Memorial Hospital

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

The hospital areas we inspected, Kingfisher ward and the endoscopy service, were visibly clean, tidy and free from clutter.

On Kingfisher ward we saw beds, trolleys and medical equipment were clean and stored correctly. Staff on Kingfisher ward used ‘I am clean’ stickers to identify the date equipment, such as commodes and monitoring equipment, were cleaned.

We saw infectious patients on Kingfisher ward were isolated in side rooms. These rooms were marked with a yellow poster to warn staff and patients of the risk of infection. Staff entering these rooms wore gloves and aprons and disposed of them when exiting the room, in line with the trust’s infection control procedures. The housekeeper we spoke with was aware of the need to use different cloths and buckets in isolation rooms.
The wards used disposable privacy curtains and we saw they were changed in line with the trust’s policy. We saw curtains in the endoscopy service had been changed in March 2018.

Clinical matrons completed hand hygiene audits every month to monitor compliance. Between January 2018 to May 2018 Kingfisher ward consistently scored 100% in the audit.

The service completed domestic cleaning audits on a regular basis depending on the risk. High risk areas phlebotomy and therapy services were audited weekly, medium risk areas for example Kingfisher ward and corridors monthly and low risk areas every three months. There were no low risk areas at the hospital. Data showed Kingfisher ward scored above 95% in April and May 2018 for high and medium risk areas.

We checked the linen cupboard and saw it was well organised with nothing stored on the floor.

Staff followed nationally recognised processes to decontaminate equipment. This included tracking of endoscopes, which included the time taken to clean and the patient the endoscope had been used on. An endoscope is a medical device for examining the inside of the body made of a long, thin, flexible tube that has a light source and camera at one end. The trust had tracking and effective auditing to ensure staff used endoscopy equipment within the required timescales after decontamination. All scopes were decontaminated on the hospital site and all items used in endoscopy other than the scope where single-use.

The patient-led assessment of the care environment (PLACE) in the interim report for 2018 showed Andover War Memorial hospital scored 96% for cleanliness.

**Basingstoke and North Hampshire Hospital**

**The service did not control all infection risks. We saw episodes of poor infection control practice on some wards we visited.**

The hospital areas we inspected were visibly clean, tidy and free from clutter. We visited eight of the twelve wards and units at the hospital. We saw beds, trolleys and medical equipment were clean and stored correctly. Staff mostly used ‘I am clean’ stickers to show equipment was clean and ready for use.

Medical staff did not always adhere to the bare below the elbows policy to prevent cross infection. On the acute assessment unit, we saw two doctors working clinically whilst wearing suit jackets, this was not in line with the trust ‘bare below the elbow’ policy. We raised this with the clinical matron at the time and this was addressed. We saw all nursing staff and other support staff followed bare below the elbows policy in the clinical areas.

Medical and nursing staff did not always wear and dispose of personal protective equipment (PPE) appropriately. On E3 respiratory ward we saw a doctor wearing gloves to take a patient’s blood but did not remove the gloves or wash their hands after the procedure. We saw them enter the treatment room and medicines room before they put the gloves in their pocket rather than disposing of them. This posed a risk of cross infection and was not in line with the trust’s infection control practices.

We also saw episodes where staff did follow infection control best practice. For example, on the acute assessment unit, we saw nurses washing their hands before and after patient contact, in line with World Health Organisation “Five moments for Hand Hygiene” guidance. On F2 ward we saw a nurse wearing gloves and an apron to empty a urine bottle.
Staff and patients had access to hand sanitiser gel dispensers and hand washing sinks in all ward areas we visited. Patients were encouraged to wash or use hand sanitiser gel before entering and when leaving the wards.

Staff on the wards used ‘I am clean’ stickers to show the date equipment, such as commodes and monitoring equipment, were cleaned. We saw equipment and surfaces were visibly clean on the wards we visited. However, on the acute assessment unit the anaphylaxis box was very dusty.

The service completed domestic cleaning audits on a regular basis depending on the risk. High risk areas such as the isolation ward and E4, the respiratory ward, were audited weekly, medium risk areas, such as general medical wards, monthly and low risk areas such as corridors every three months. Data showed the overall cleaning score was above 95% in April and May 2018 for high and medium risk areas.

Patients who had or were at risk from infections were appropriately segregated in single rooms. Staff placed warning signs on the isolation rooms to alert staff and visitors of the patient’s infection status. All wards we visited had side rooms, which staff could use to isolate patients who had infectious diseases. Clinical matrons we spoke with told us they usually had enough side rooms to isolate patients. On F2 ward the clinical matron told us they had only had to move a patient off the ward due to lack of availability of a side room once in the past six months.

Nurses screened inpatients for methicillin-resistant staphylococcus aureus (MRSA) and MSSA in line with the trust infection control policy. MRSA is a type of bacterial infection which is resistant to antibiotics and can cause harm to patients. The trust audited MRSA screening within 48 hours of admission. Between April 2017 to October 2017 at Basingstoke and North Hampshire Hospital compliance was consistently above 90%.

Clinical matrons regularly completed hand hygiene audits for the wards. The trust set a target of 100% compliance with hand hygiene audits. From January 2018 to June 2018 the hand hygiene audits for the acute assessment unit, cardiology, coronary care unit, E1, E3, E4, isolation ward achieved the 100% target. Wards E2, F2 scored below the target in two out of the six months January 2018 to June 2018.

Some wards did not consistently complete hand hygiene audits. Wards E1, F1 and F2 had not completed one out of six audits in the past six months. Data showed hand hygiene audits were not competed between January 2018 and April 2018 on F3 ward. On Overton unit the hand hygiene compliance score was 80% in January 2018 and 50% in February 2018. There were no further audits March 2018 to May 2018. This meant the trust could not be assured infection control best practice was being followed and poor hand hygiene practice was being addressed.

We observed in the waiting area of the Candover Clinic seating was unsuitable for a hospital environment as it could not be cleaned effectively to infection prevention standards. The manager was aware of this and new chairs were on order.

The patient-led assessment of the care environment (PLACE) interim 2018 report scored Basingstoke and North Hampshire Hospital 98% for cleanliness.

Royal Hampshire County Hospital

The service did not control all infection risks. We observed episodes of poor infection control practice on some wards we visited.

The hospital areas we inspected were visibly clean, tidy and free from clutter. We visited six of the eight wards and units at the hospital. We saw beds, trolleys and medical equipment were clean.
and stored correctly. Staff used of ‘I am clean’ stickers to show equipment was clean and ready for use. A patient we spoke with on Freshfield ward told us the ward was kept ‘extremely clean.’

Medical staff did not always adhere to the bare below the elbows policy to prevent cross infection. We observed one doctor on Shawford was providing care to patients whilst not bare below the elbows.

Staff did not always follow infection control best practice. For example, we observed a nurse on the endoscopy service cannulate a patient did not follow personal protective equipment (PPE) procedures.

We also observed episodes where staff did follow infection control best practice. For example, we observed a nurse take a blood monitoring reading on a patient. They wore an apron and gloves and washed their hands appropriately. We saw personal protective equipment, such as disposable gloves and aprons, were readily available on all wards.

There was enough hand sanitiser gel dispensers and hand washing sinks in all ward areas we visited. Patients were encouraged to wash or gel their hands before entering or leaving wards.

Staff on all wards used ‘I am clean’ stickers to show the date equipment, such as commodes and monitoring equipment, were cleaned. We saw equipment and surfaces were visibly clean on the wards we visited. However, we saw there was thick dust on the resuscitation trolley on Victoria ward. This was raised to the sister at the time of our inspection and they told us it would be cleaned.

The service completed domestic cleaning audits on a regular basis depending on the risk. High risk areas, such as the endoscopy service and Victoria, the gastroenterology ward, were audited weekly, medium risk areas, such as general medical wards, monthly and low risk, non-clinical, areas every three months. Data showed the overall cleaning score was above 95% in April and May 2018 for high and medium risk areas.

Patients who had or were at risk from infections were mostly segregated in single rooms. Staff placed warning signs on the isolation rooms to alert staff and visitors of the patient’s infection status. All wards we visited had side rooms, which staff could use to isolate patients who had infectious diseases. Clinical matrons we spoke with told us they usually had enough side rooms to isolate patients.

However, in the McGill acute admission unit, patients who were suspected as high risk of infections including diarrhoea and vomiting were nursed in the open bays with curtains around the bed. The clinical matron confirmed that this was not in line with the trust’s infection control and prevention procedures and they ‘struggled’ with compliance due to inadequate numbers of side rooms to isolate patients until the results of tests were received.

Staff screened inpatients for methicillin-resistant staphylococcus aureus (MRSA) and MSSA in line with the trust infection control policy. MRSA is a type of bacterial infection which is resistant to antibiotics and can cause harm to patients. The trust audited MRSA screening within 48 hours of admission.

Clinical matrons regularly completed hand hygiene audits for the wards. The trust set a target of 100% compliance with hand hygiene audits. Results of the hand hygiene audits across wards were mixed. From January 2018 to June 2018 the hand hygiene audits for Clarke unit achieved the trust target of 100%. In February 2018 Freshfield and Wykeham wards scored 90% but achieved the 100% target in all other months. On Twyford ward the hand hygiene audit score was 90% in January, March and May 2018 and 80% in February 2018. Results improved to 100% in
April and June 2018. From January 2018 to May 2018 the hand hygiene audit for the acute frailty unit did not meet the trust target of 100% in January 2018, scoring 60%.

Some wards did not consistently complete hand hygiene audits. Clarke, Freshfield and Shawford wards had not completed one out of six audits in the past six months. Wykeham ward had not completed two of six audits in the past six months. The endoscopy service had only completed one hand hygiene audit between January and May 2018. This meant the trust could not be assured infection control best practice was being followed and poor hand hygiene practice was being addressed.

The wards used disposable privacy curtains and we saw they were changed in line with the trust’s policy. We saw curtains in the McGill acute assessment unit had been changed in June 2018. Curtains had been changed in April 2018 on Twyford ward. Curtains had been changed in March 2018 on the endoscopy service.

There was a system in place for the management and disposal of waste, we observed staff followed their process to segregate infected materials.

In the endoscopy service we saw staff followed nationally recognised processes to decontaminate equipment. This included tracking of scopes, the time taken to clean and the patient the scope had been used on. The trust followed Department of Health guidance on decontamination of flexible endoscopes. The access to the endoscopy treatment area was restricted as part of infection control management. Tracking and effective auditing ensured staff used endoscopy equipment within the required timescales after decontamination. The service completed endoscopy decontamination audits every month. We saw in patient records a record of the scope decontamination and serial number was attached. The trust also had an electronic system to log washing of scopes, which patients they had been used on and when so the process was fully traceable. All scopes were decontaminated on the hospital site. All items used in endoscopy other than the scope were single-use.

The patient-led assessment of the care environment (PLACE) interim 2018 report scored the Royal County Hampshire Hospital scored 98% for cleanliness.

Environment and equipment

Andover War Memorial Hospital

Emergency equipment was not checked regularly and in line with the trust’s policy to ensure that it was safe to use and available in an emergency. People may be put at risk as the staff were unclear about their internal process for accessing help and support in an emergency.

We found four out of five pieces of equipment were out of date for safety testing on the endoscopy service. We raised this with staff at the time of inspection. They were not aware this equipment had not been tested in line with the trust’s policy and may not be fit for purpose.

Staff we spoke with were aware of how to report faulty equipment for repair. The medical equipment department managed routine repair of equipment. The service labelled the equipment with asset numbers and kept a log of when safety testing checks were due. We saw beds, furniture and electrical equipment were labelled with asset numbers and labels showing service dates. However, staff had not identified or reported out of date equipment which had not been tested in order for action to be taken. This included the nebuliser and the electrocardiography (ECG) machine on the endoscopy service which were overdue for safety testing.
Staff we spoke with told us they did not have problems accessing equipment such as pressure relieving mattresses for patients.

Staff in the endoscopy service showed us a trolley which they said was their resuscitation trolley. However, this did not contain the appropriate equipment as recommended by the resuscitation council. The grab bag contained emergency drugs in the front pocket of the bag, this pocket was secured with a tamper proof tag. Therefore, daily checks did not include checking these drugs. They would only be checked if the tag had been tampered with. In addition to the grab bag, on a separate shelf there were two separate anaphylaxis drug boxes, these were not tamper proof and it was unclear if these were checked regularly, there was also a suction machine, and a defibrillator. An oxygen cylinder was on a separate trolley that sat next to the rest of the emergency equipment.

The endoscopy service shared its resuscitation equipment with the birthing centre at Andover War Memorial hospital. The resuscitation equipment was stored in the unit during the day and once the last patient had left the unit at 6pm the equipment would be taken to the birthing centre where it would remain overnight. It would be brought back to the day surgery unit usually before the first patient arrived. The senior nursing staff at the unit told us if the resuscitation equipment was not there in the morning they would phone the birthing centre to ask for the equipment to be brought over to them. We were told that the day surgery unit checked the equipment, it was not checked whilst it was at the birthing centre and this was confirmed by a nurse we spoke to in the birthing centre and documentation we reviewed. As the endoscopy service was closed at the weekends, the resuscitation equipment was taken to the birthing centre at 6pm on a Friday, remained at the birthing centre for the weekend and was brought back to the day surgery unit on a Monday morning. There was no assurance that equipment would be fit for purpose as checks were not always carried out. There seemed to be a lack of responsibility and no clear policy of whom should return the equipment.

Staff told us in the event of a medical emergency they would dial 2222 and 999 and the hospital resuscitation team would administer emergency drugs. Nursing staff were only trained in basic life support which meant staff were able to maintain an airway and carry out chest compressions in the event of a medical emergency but they could not carry out tracheal intubation or administer emergency drugs.

We raised this risk with the trust and they responded that the arrangement was appropriate based on their assessment of the risk. We spoke with the head of the trust resuscitation council and they told us resuscitation trolleys varied across the hospital sites. This did not assure us that the trust understood the risk that resuscitation equipment was not fit for purpose at the Andover War Memorial hospital site.

We reviewed the trust wide resuscitation audit and found an initial audit of resuscitation equipment on Kingfisher ward had been done in November 2017. The trust had implemented a new resuscitation audit process as of January 2018. This had not been implemented at Andover War Memorial Hospital at the time of our inspection.

The trust took into consideration people who were living with dementia and had adapted the environment to include clear signage to help identify washing and toilet facilities.

**Basingstoke and North Hampshire Hospital**

Daily checks on emergency equipment were completed and equipment was safe and ready for use.
Wards and departments had resuscitation equipment stored in tamper evident trolleys that staff checked daily. We saw staff had fully completed daily checks for May and June 2018 on wards E4 and F2.

One resuscitation trolley was shared between F1, F2 and F3 we asked two clinical matrons whether this had been risk assessed and they were not aware if it had been. We raised this with the trust following the inspection and they responded the provision was appropriate based on their assessment of the risk.

We reviewed the trust wide resuscitation audit and found an initial audit of resuscitation equipment at Basingstoke and North Hampshire hospital had been completed on all medical wards. The new resuscitation audit process had been implemented in five out of eleven medical areas and was being rolled out to other areas at the time of our inspection.

The equipment that was on wards and departments was all in date for servicing and safety checked. We checked seven items of equipment across wards and found they were all in date for safety testing. The medical equipment department managed routine repair of equipment. The service labelled all equipment with asset numbers and kept a log of when safety testing was due.

We saw beds, furniture and electrical equipment were labelled with asset numbers and labels showing service dates.

The trust took into consideration people who were living with dementia and had adapted the environment to include clear signage to help identify washing and toilet facilities.

In the store room on F1 ward some boxes of incontinence pads were stored on the floor, this was not in line with good practice for storing equipment to ensure it is clean and dry.

We saw on F1 ward Control of Substances Hazardous to Health (COSHH) items were secured in a locked cupboard.

Royal Hampshire County Hospital

There was a lack of assurance equipment was safe and ready to use. Checks on emergency equipment were not always completed daily.

Twyford, the designated stroke ward, had two hyper-acute stoke bays with five male and five female beds. There was a fully fitted therapy room to support patients’ rehabilitation process. The stroke unit had a large bathroom which allowed patients to be wheeled in on their beds and hoisted safely to the adapted bath. Staff were very proud of the facility which supported their patients and met their needs.

The trust took into consideration people who were living with dementia and had adapted the environment which included signage and colour coded doors to help identify washing and toilet facilities.

The endoscopy service was well maintained and had areas for pre- and post-procedures which ensured that male and female patients ready for their procedures were provided with appropriate waiting areas.

Staff told us that the endoscopy service had lost their accreditation due to some environmental issues and not meeting the mixed sex facilities. The trust had undertaken a review of the facility in order to comply and the endoscopy lead had an action plan to address the issues following the review.

On Twyford ward we observed that not all the bays had washing facilities, staff told us patients had to access this facility in the other bays. A senior nurse discussed adapting one of the toilets
into a separate shower facility which would have positive impact for patients, there was no timescale for this project at the time of the inspection.

Staff in all clinical areas had access to emergency equipment, including portable oxygen, suction and defibrillators stored on purpose-built, tamper-evident trolleys. Records of resuscitation equipment daily checks showed staff did not always complete daily checks of emergency equipment in line with the trust’s policy.

On Shawford ward we saw daily checks of the resuscitation trolley were recorded every day in June 2018. Staff had made a note one drug on the trolley would expire at the end of June 2018 as a reminder to replace it. However,

- On Victoria ward, whilst the last three months of daily checklist records showed checks had been completed, we were not assured they had been completed effectively as we found two expired items on the trolley. The expired items were handed to the ward sister at the time of the inspection to replace.
- On the McGill acute assessment unit, we reviewed records of staff’s daily checks of resuscitation equipment. We found in April 2018 three dates were not completed and in May 2018 one date was not completed.
- On the endoscopy service, when we visited on 5 July, we found the last date the resuscitation trolley had been checked was the 1 July and the last five checks had not been completed. Staff confirmed the trolley should be checked each morning at the beginning of the list and the sister told us they would remind staff of the importance of daily checks at the next staff meeting. This was a risk that emergency equipment may not be available and patients’ safety and well-being compromised.

We reviewed the trust wide resuscitation audit and found an initial audit of resuscitation equipment at Royal Hampshire County hospital had been completed for all medical areas. The new resuscitation audit process due for implementation in January 2018 had not yet been implemented at Royal Hampshire County hospital at the time of inspection.

The equipment that was on wards and departments was not always in date for servicing and safety checks. In total across the wards we visited, six out of 15 items of equipment were out of date for safety testing.

- On Twyford ward we checked three items of equipment and found two were within date for safety testing and one telemonitor was overdue for safety testing. We brought this to the attention of the senior nurse during the inspection.
- On McGill acute assessment unit, of six items checked, five were in date for safety testing, one telemonitor had expired in May 2018.
- On Shawford ward we checked six items of equipment, four were within date for safety testing, one blood pressure monitor was due for safety testing on 5 May 2018 and one scale for weighing a patient in a hoist was due 14 June 2018. The clinical matron was not aware the item was due for servicing.

On Shawford ward the hoist was out of date for safety testing. The manual handling lead could not clarify why the hoist had two stickers with different dates and which date staff should take note of. We were told this risk had been raised with the manual handling team on several occasions but no action had been taken and the known risk was not on the risk register. Therefore, despite the trust being aware of this risk no action had been taken to address it.
Staff we spoke with were aware of how to report faulty equipment for repair. The medical equipment department managed routine repair of equipment. The service labelled all equipment with asset numbers and kept a log of when safety testing was due. We saw beds, furniture and electrical equipment were labelled with asset numbers and labels showing service dates. However, on Freshfield ward the label of an item of equipment said it was due for servicing in June 2018. When we raised this with the clinical matron they told us the item had been serviced in June 2018.

Waste segregation and removal was seen to be working effectively.

The trust took into consideration people who were living with dementia and had adapted the environment to include clear signage to help patients find washing and toilet facilities.

Assessing and responding to patient risk

Trust wide

Trust wide Patient moves per admission

From March 2017 to February 2018, 76.4% of individuals did not move wards during their admission, and 23.6% moved once or more.

The below table shows ward moves by site:

<table>
<thead>
<tr>
<th>Number of ward moves</th>
<th>Basingstoke and North Hampshire Hospital</th>
<th>Royal Hampshire County Hospital</th>
<th>Andover War Memorial Hospital</th>
<th>Total</th>
<th>Percentage of moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>3,433</td>
<td>3,749</td>
<td>37</td>
<td>7,219</td>
<td>76.4%</td>
</tr>
<tr>
<td>1</td>
<td>709</td>
<td>769</td>
<td>112</td>
<td>1,590</td>
<td>16.8%</td>
</tr>
<tr>
<td>2</td>
<td>195</td>
<td>192</td>
<td>52</td>
<td>439</td>
<td>4.7%</td>
</tr>
<tr>
<td>3</td>
<td>55</td>
<td>60</td>
<td>16</td>
<td>131</td>
<td>1.4%</td>
</tr>
<tr>
<td>4+</td>
<td>21</td>
<td>35</td>
<td>13</td>
<td>69</td>
<td>0.7%</td>
</tr>
<tr>
<td>Total</td>
<td>4,413</td>
<td>4,805</td>
<td>230</td>
<td>9,448</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Routine Provider Information Request – Ward Moves)

At the time of inspection, the trust was introducing NEWS2, an updated version of the NEWS score.

Andover War Memorial Hospital

Staff completed and updated risk assessments for patients. However, the process for responding to an emergency was not effective.

Nurses on the ward used a nationally recognised tool, the national early warning system (NEWS) to identify deteriorating patients. Staff told us they would arrange emergency transfers to acute medical wards through 999 ambulance call if necessary.

However, we were not assured of the process for responding to an emergency. At Andover War Memorial Hospital, the nurses carrying the emergency bleep were only trained to deliver basic life support and were confused about their responsibilities. Some staff, who carried the emergency bleep seeing themselves as first responders, and others who stated they didn't always go if the bleep went off and were not sure what equipment they should take. This meant there was not a
consistent approach to the response to the emergency bleep.

The trust completed audits of compliance with the completion of NEWS scores. Data showed between March 2017 to February 2018 Andover War Memorial Hospital achieved the trust target of 90% compliance in 11 out of 12 monthly audits.

Nurses we spoke with were aware of the trust sepsis policy and had completed training on sepsis management.

Staff on the endoscopy service had recently started completing pressure ulcer checklists for frail patients.

**Basingstoke and North Hampshire Hospital**

**Staff did not always assess, monitor or manage risks to people who used the service. We were not assured the national early warning system was always used correctly to identify and escalate patient needs appropriately.**

Nurses carried out comprehensive risk assessments for patients on admission. These included: falls risk assessment, use bed rails assessments, pressure area risk assessment and a malnutrition universal screening tool (MUST) assessment. We observed risk assessments were recorded in paper nursing records.

Staff screened all patients for sepsis, the department had a sepsis link nurse and the criteria and protocol for escalation was on the form. The clinical matron explained the very clear sepsis pathway and all band 6s were competency trained in use of the sepsis pathway. Staff we spoke with were aware of how to spot the signs of sepsis. Staff we spoke with on CCU confirmed they had training on using the sepsis pathway.

Nursing staff were aware of how to escalate their concerns to a doctor if a NEWS indicated a patient had deteriorated. Healthcare assistants we spoke with were aware of how to escalate their concerns about a deteriorating patient to the nurse in charge.

Nurses used a nationally recognised tool, the national early warning system (NEWS), to identify deteriorating patients. However, NEWS charts were not always completed correctly and guidance on frequency of observations followed. We reviewed seven NEWS charts across F1 and Overton ward and found instances where scores were incorrectly totalled up in all seven records reviewed. On the acute assessment unit, we found the override criteria were not completed (7 + 5 + 6).

Across the wards we visited we noted that seven of the seven NEWS charts we reviewed included NEWS scores that were not correctly calculated and therefore the correct frequency of observations were not undertaken. This meant that deteriorating patients may not be identified in a timely manner and appropriate interventions may not take place.

The trust completed audits of compliance with the completion of NEWS scores. Data submitted showed poor compliance with NEWS audits between March 2017 to February 2018 on the following wards –

- E2 ward did not meet the trust target of 90% in eight of twelve months, with non-compliance ranging between 30% and 87%
- the acute assessment unit did not meet the trust target of 90% in seven of twelve months, with non-compliance ranging between 16% and 80.0%
- E1 ward did not meet the trust target of 90% in seven of twelve months, with non-compliance ranging between 45% and 89%
- E4 ward did not meet the trust target of 90% in five of twelve months, and did not submit data one month, non-compliance ranged between 32% and 88%
- the coronary care unit did not meet the trust target of 90% in two of twelve months, and did not submit data one month, non-compliance ranging between 50% and 71%
- E3 ward did not meet the trust target of 90% in two of twelve months, with non-compliance ranging between 61% and 86%
- the cardiology ward did not meet to meet the trust target of 90% in two of twelve months, with non-compliance ranging between 75.0% and 83.3%

A critical care outreach team supported the wards with deteriorating patients. Staff we spoke with on CCU knew how to access the team and told us they were responsive and supportive. We spoke with a staff member of the outreach team who supported the staff and told us that the process for escalation worked well. Staff told us that they received ‘very good’ support from the outreach team which provided cover seven days a week.

A clinical matron told us the process for contacting critical care outreach team ‘a bit of a grey area’ and the trust was in the process of writing a standard operating procedure to clarify the process.

A clinical matron told us planned major incident training was due to take place today but was cancelled due to our visit. They had not been involved with any trust wide simulation training since they had been in post.

The acute assessment unit had a standard operating procedure which included assessing the patients’ risk whilst they were on a trolley. The clinical matron was trying to get the specialty consultants down to the unit at 9am to assess patients and plan their next steps, at the time of our inspection some patients who arrived during the night were having to wait until 12 noon.

Risk assessments for risks to self, others and from others were not routinely completed for patients with a mental health or learning disability diagnosis. Generic risk assessments covering risk of harm to self, others and from others were completed on the acute assessment unit, however we did not see evidence of these risk assessments being completed on the other medical wards.

Nurses used the Rockwood scoring system to assess patient’s level of frailty, a comprehensive geriatric assessment done by frailty team. The tool was used to assess patient’s needs and identify the most appropriate support.

Staff managed patients who were at risks of falls. Patients who were at risks of falls were accommodated in bays closer to the nurses’ station where they could be easily observed. We saw falls prevention socks were widely used which helped to alert staff of patients at risks of falls. On F1 ward the nurses’ station had been removed and replace with a table used by patients and staff. On other wards we observed nurses were based in the bays which helped in monitoring patients. This encouraged interaction between staff and patients and made it easier for staff to observe patients at risk of falls.

We saw that falls risk assessments had been completed for patients but it was not always clear what the outcome of the assessment was and whether a falls care plan had been developed with action to mitigate the risk.
Nurses had daily ‘safety huddles’ where current patient risk issues such as falls and pressure ulcers were discussed.

The World Health Organisation (WHO) safety checklist was not fully completed in endoscopy in three out of the six records reviewed. The sign out section was not completed in three out of six records. We requested evidence of audit of the WHO checklist and the trust responded they had not carried out a WHO checklist audit for endoscopy in the past 12 months. This meant the trust could not be assured the WHO checklist was being fully completed to ensure patient safety.

On F1 ward a patient with necrotic toes and a leg ulcer had no wound care plan. The wound care being delivered involved the use of Potassium permanganate, this was being incorrectly diluted as the fluid used to dilute it was being estimated. As the concentration of the solution was too strong it was staining the leg. Therefore, by not diluting the solution with the correct amount of solution the patient was placed at risk of receiving inconsistent care.

On E4 ward two diabetic patients had not had their blood sugar levels monitored for 24 hours. This meant that any significant changes in their blood sugars would not be identified and the appropriate actions taken as staff were not following the patient’s individual care plans.

Royal Hampshire County Hospital

Staff did not always assess, monitor or manage risks to people who used the service. We were not assured the national early warning system was always used correctly to identify and escalate patient needs appropriately.

Nurses carried out comprehensive risk assessments for patients on admission. We observed risk assessments were recorded in paper nursing records. The following risk assessments were completed on admission: falls risk assessment, use bed rails assessments, pressure area risk assessment and a malnutrition universal screening tool (MUST) assessment.

All patients were screened for sepsis, the department had a link nurse and the criteria and protocol for escalation had been developed. Staff we spoke with were aware of how to spot the signs of sepsis.

Nurses used a nationally recognised tool, the national early warning system (NEWS), to identify deteriorating patients. We were not assured NEWS charts were completed correctly and guidance on frequency of observations followed. We reviewed three NEWS charts on Victoria ward and found instances where NEWS scores were calculated inaccurately three out of three charts reviewed.

Nursing staff were aware of how to escalate their concerns to a doctor if NEWS scores had changed and indicated deterioration in a patient’s condition. Healthcare assistants we spoke with were aware of how to escalate their concerns about a deteriorating patient to the nurse in charge. A nurse we spoke with in the discharge lounge was aware of how to escalate a deteriorating patient. A clear escalation process was displayed on the wall including the number to call in an emergency.

The trust completed audits of compliance with the completion of NEWS scores. Data showed variable compliance with NEWS audits between March 2017 to February 2018 on the following wards –

- Clifton ward did not meet the trust target of 90% in nine out of the past 12 months, non-compliance ranged between 0% an 88.5%
- Clarke ward did not meet the trust target of 90% in three of the past 12 months, non-compliance ranged between 7.7% and 88%
- Wykeham ward did not meet the trust target of 90% in two of the past 12 months, non-
compliance ranged between 85.7% and 86.4%.
- Freshfield ward met the trust target of 90% in 10 out of 12 months, the ward was non-compliant in July 2017, scoring 70.8% and did not submit data in March 2017
- McGill acute assessment unit met the trust target of 90% in 11 out of 12 months, the unit was non-compliant in February 2018 scoring 80%
- The acute medical cardiac unit did not submit any data to the NEWS audit in the past 12 months

Nurses did not use the NEWS system on the endoscopy service. However, the unit did not routinely use any tool such as the national early warning scores (NEWS) to identify deteriorating patients. This meant staff did not have a consistent escalation process they followed to ensure prompt access to medical support. Instead they recorded observations on patients before, during and after the procedure. We saw in all six patient records we reviewed that nurses’ observations were recorded in patient notes.

Nursing staff we spoke with reported they had good support from doctors and the critical care outreach team whenever a patient deteriorated.

Staff managed patients who were at risks of falls proactively. Nurses place patients who were at risks of falls closer in bays where they could be observed most easily. We saw falls prevention socks were used. Clinical matrons encouraged staff to write up notes in patient bays so they could continue to observe patients who were at risk of falls. On Wykeham the nurses station had been removed so nurses always worked in patient bays and on Freshfield ward nurses worked in bays and on a table in a communal area that was shared with patients. This encouraged interaction between staff and patients and made it easier for staff to observe patients at risk of falls.

Nurse safety huddles supported the identification and management of patient risk. Nurses had daily safety huddles where current patient risk issues such as falls and pressure ulcers were discussed to ensure all staff were aware of actions to mitigate risks.

The World Health Organisation (WHO) checklist was not fully completed in endoscopy in three out of the six records reviewed on the endoscopy service at Royal Hampshire County Hospital. The sign out section was not completed in three out of six records. We requested evidence of audit of the WHO checklist and the trust responded they had not carried out a WHO checklist audit for endoscopy in the past 12 months. This meant the trust could not be assured the WHO checklist was being fully completed to ensure patient safety.

On Twyford stroke unit, there were clear guidelines which had been developed for the management of naso-gastric tube (tube inserted in the patient’s nose for feeding purposes) for patients whose swallowing was compromised following a stroke and other neurological incidents. We reviewed the trusts ‘nasogastric tube insertion in adults’ policy and saw that it was appropriate and up to date (authorise October 2017, for review July 2020). The policy included a competency framework for insertion of a nasogastric tube and an assessment and monitoring form. The policy included actions that staff should take if they were unable to withdraw any aspirates from the naso-gastric tube. On Twyford ward we saw evidence of input from the dietician in patients notes we reviewed and a completed nasogastric tube positioning chart.

The naso-gastric tube guidelines included that the tube should be checked at least once a day for patients on continuous feeds. Staff checked that the tube was in the correct position prior to administering bolus feeds as per guidelines, in the two records we reviewed there was evidence of these checks. For patients who had a new tube inserted and were nil by mouth or the pH from the...
aspirate was above 5, the ward sister confirmed that a chest x-ray would be requested to confirm
the position of the tube, particularly if the patient did not have adequate or poor swallowing
reflexes.

**Nurse staffing**

**Trust wide**

The trust has reported their nursing staffing numbers below as at February 2018, with a staffing
rate of 76.1%.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at February 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire Hospitals NHS Foundation Trust</td>
<td>590.2</td>
<td>448.9</td>
<td>76.1%</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From March 2017 to February 2018, the trust reported a vacancy rate of 24.2% in medicine,
compared to the 8% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 27.0%
- Royal Hampshire County Hospital: 28.4%
- Andover War Memorial Hospital: 13.2% (Kingfisher ward)
- Multi-site: 12.3%

Elderly management had the highest annual vacancy rate of 73% at Basingstoke and North
Hampshire Hospital, followed by Overton ward with 65.4%. Twyford ward had the highest annual
vacancy rate at Royal Hampshire County Hospital with 41.9%, followed by endoscopy service with
33.3%. There were two multi-site areas that carried 100% annual vacancy: winter pressure nursing
and the cardiology department.

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

**Turnover rates**

From March 2017 to February 2018, the trust reported a turnover rate of 10.0% in medicine,
compared to the 12% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 7.9%
- Royal Hampshire County Hospital: 11.0%
- Andover War Memorial Hospital: 35.6% (Kingfisher ward)

The discharge lounge had the highest annual turnover rate with 92.3% at Basingstoke and North
Hampshire Hospital, whilst the discharge team had the highest annual turnover rate at Royal
Hampshire County Hospital with 88.4%.

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

**Sickness rates**

From March 2017 to February 2018, the trust reported a sickness rate of 3.8% in medicine,
compared to a 3.5% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 3.3%
- Royal Hampshire County Hospital: 4.2%
- Andover War Memorial Hospital: 6.8% (Kingfisher ward)

The discharge lounge at Basingstoke and North Hampshire Hospital had the highest annual sickness rate of 19.4%, followed by rheumatology with 13.7%. Wykeham ward at Royal Hampshire County Hospital had the highest sickness rate with 8.7%, followed by Shawford ward with 6.4%.

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

**Bank and agency staff usage**

Please note that we are unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

The below table shows total shifts filled by bank/agency qualified nursing staff and shifts left unfilled from March 2017 to February 2018 in medicine at Hampshire Hospitals NHS Foundation Trust by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and North Hampshire Hospital</td>
<td>3,308</td>
<td>1,156</td>
<td>2,495</td>
</tr>
<tr>
<td>Royal Hampshire County Hospital</td>
<td>2,239</td>
<td>635</td>
<td>2,261</td>
</tr>
<tr>
<td>Andover War Memorial Hospital</td>
<td>342</td>
<td>1</td>
<td>52</td>
</tr>
<tr>
<td>Multi-site</td>
<td>469</td>
<td>N/A</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>6,358</td>
<td>1,792</td>
<td>4,905</td>
</tr>
</tbody>
</table>

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

The trust measured the fill rates for registered nurses and health care assistant staff on day and night shifts. We reviewed safer staffing information for February to May 2018 that was presented to the trust board. The records showed medical wards were not filling all their required shifts and not meeting the trust’s fill rate of 90% for all nursing shifts.

The trust employed five nurse endoscopists who worked across all three hospital sites. At the time of the inspection this met the needs of the service. The trust did not use agency staff due to the specialist nature of the nurse endoscopists role.

**Andover War Memorial Hospital**

There was not always enough nurse staffing at night on Kingfisher ward. This may impact on the care and support people receive.

We reviewed safer staffing information for February to May 2018 that was presented to the trust board. The records showed that Andover War Memorial Hospital was filling over 90% of registered nurse and healthcare assistant shifts in February, March, April and May 2018.

We reviewed incident reports for the period April 2017 to March 2018 and found there were three incidents reported relating to insufficient registered nurse staffing for the number of patients on the
ward, one trained nurse to 22 or 21 patients. One incident was rated as low harm, and the other two indicated no patient harm. The low harm incident was where there was not enough staff available to provide one to one care to a patient living with dementia who was verbally and physically aggressive. Following the incident, a debrief for staff took place and the process for accessing support from the dementia team made clearer to staff.

Staffing levels were as planned on Kingfisher ward at time of inspection. At the time of the inspection there were four registered nurse vacancies with three nurses planned to begin work on the ward in the next two months. Some staff we spoke with raised concerns about staffing at night with one registered nurse for 22 patients and the impact this had on patient care. We reviewed staffing at night on Kingfisher ward and found there were:

- four instances when there had been only one trained nurse on duty on Kingfisher ward overnight between 19 March and 15 April 2018.
- seven instances when there had been only one trained nurse on duty on Kingfisher ward overnight 16 April and 13th May 2018.
- five instances when there had been only one trained nurse on duty on Kingfisher ward overnight 14 May to 10 June 2018.

The trust told us the risk of low nurse staffing cover overnight on Kingfisher was mitigated by staff from the hospice next to the ward giving support when necessary.

**Basingstoke and North Hampshire Hospital**

**Nursing staff vacancy rates were high on elderly care and respiratory wards. The fill rate for nursing staff was not always met through use of bank or agency staff.**

We reviewed safer staffing information for February to May 2018 that was presented to the trust board. The records showed Basingstoke and North Hampshire Hospital was not always meeting the target of filling 90% of all nursing shifts.

In the February 2018 safer staffing report, seven wards, E1, E3, E4, F1, F2, F3 and the isolation ward did not meet the fill rate target for registered nurses on day shifts. Where wards did not meet the target, the fill rates ranged from 68% to 88%.

In the March 2018 safer staffing report, six wards, E1, E3, E4, F1, F2 and the isolation ward did not meet the fill rate target for registered nurses on day shifts. Where wards did not meet the target, the fill rates ranged from 66% to 84.52%.

In the April 2018 safer staffing report, there was some improvement. Four wards, E1, E4, F2 and the isolation ward did not meet the fill rate target for registered nurses on day shifts. Where wards did not meet the target, the fill rates ranged from 67.76% to 76.58%.

In the May 2018 safer staffing report, five wards, E1, E3, E4, F2 and the isolation ward did not meet the fill rate target for registered nurses on day shifts. Where wards did not meet the target, the fill rates ranged from 65.57% to 88.98%.

Overton ward was not included in the safer staffing report. We reviewed the staffing rotas for the past three months and found that bank and agency staff were used to cover registered nurse vacancies. Due to the registered nurse vacancies in May 2018 the number of patients cared for on the ward was reduced to 15-17 patients from 25 with an establishment of two registered nurses per shift. Rotas showed that most registered nurse shifts in May and June 2018 were covered by bank staff. At the time of the inspection there were no permanent staff nurses working on Overton ward and the unit was staffed by agency staff working a line of work.
The trust had identified nurse staffing as a risk on the medical division risk register. A risk was also included that detailed ongoing issues with high vacancy levels on E1, E3 and the isolation ward. The mitigation for the staffing risk was appropriate. The trust mitigated the nurse staffing risk by moving staff between wards, continuing active national recruitment, using bank and agency staff, and reviewing staffing skill mix.

We reviewed incident reports for the period April 2017 to March 2018 and found 27 incidents relating to insufficient staffing levels were reported. Of these eight staffing incident reports related to E3 ward.

We requested the standard operating procedure for patients with alternative airways or non-invasive ventilation (NIV) who were nursed on E3 respiratory ward. The policy stated the ward needed a minimum of five trained nurses per shift during the day plus a supervisory sister and three trained nurses at night. We reviewed the staffing rotas for the past three months and found that nursing staffing of five nurses during the day was not met most of the time. The trust responded due to staffing vacancies they were usually staffing the ward with four trained nurses on day and three trained nurses at night. The service was managing the staffing with band staff and agency.

On F1 ward staff we spoke with were aware of the staffing escalation process. We saw that the staffing escalation flowchart was included in the communication folder for F2 and F3 wards. Staff told us there were not always enough staff to provide the necessary one to one supervision for patients living with dementia.

On the acute assessment unit regular agency staff were retained by offering support with revalidation.

Royal Hampshire County Hospital

Nursing staff vacancy rates were high on elderly care wards and the respiratory ward. The fill rate was not always met through use of bank and agency staff. This may impact on the care and support people receive.

We reviewed safer staffing information for February to May 2018 that was presented to the trust board. The records showed that Royal Hampshire County Hospital was not always meeting the target of filling 90% of all nursing shifts.

In the February 2018 safer staffing report, five wards, Clarke, Shawford, Twyford, Victoria and Wykeham did not meet the fill rate target for registered nurses on day shifts. Where wards did not meet the target, the fill rates ranged from 50% to 82.70%

In the March 2018 safer staffing report, five wards, Clarke, Shawford, Twyford, Victoria and Wykeham did not meet the fill rate target for registered nurses on day shifts. Where wards did not meet the target, the fill rates ranged from 51.47% to 81.56%

In the April 2018 safer staffing report, six wards, Clarke, Freshfield, Shawford, Twyford, Victoria and Wykeham wards did not meet the fill rate target for registered nurses on day shifts. Where wards did not meet the target, the fill rates ranged from 52.42% to 78.10%

In the May 2018 safer staffing report six wards, Clarke, Freshfield, Shawford, Twyford, Victoria and Wykeham did not meet the fill rate target for registered nurses on day shifts. Where wards did not meet the target, the fill rates ranged from 50.00% to 83.95%.

We reviewed incident reports for the period April 2017 to March 2018 and found that 17 incidents relating to insufficient staffing levels were reported. Of these, five related to Shawford, respiratory
ward. The majority were graded as no harm, one was graded as low harm as insufficient staffing had caused a delay in treatment on McGill acute assessment unit.

Staff we spoke with told us there were strict criteria for admission to the discharge lounge to ensure staffing levels were safe and appropriate for the number of patients in the discharge lounge.

The service used a safer staffing acuity and dependency tool and professional judgement to estimate nurse staffing requirements. The associate director of nursing and the chief nurse met with each clinical matron or ward sister to review establishments and the needs of the ward based on professional judgement and data from the electronic incident reporting system. On a day to day basis the clinical matron of the day would assess the overall need by speciality and move staff or agree temporary staffing per shift.

Staff in endoscopy told us that at times they struggled with staffing and used their own staff who worked extra shifts to cover the unit. However, they confirmed that they felt staffing was safe and there had been no incident where they had to cancel planned surgery at the unit. Staff were not aware that data was collected. The duty rota showed that they were meeting their planned number of staff.

**Medical staffing**

**Trust wide data**

The trust has reported their medical staffing numbers below as at February 2018, with a staffing rate of 94.2%.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at February 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire Hospitals NHS Foundation Trust</td>
<td>204.9</td>
<td>193.0</td>
<td>94.2%</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From March 2017 to February 2018, the trust reported a vacancy rate of 8.2% in medicine, compared to the 8% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: over-established by 0.3%
- Royal Hampshire County Hospital: over-established by 12.9%
- Multi-site: 26.1%

Elderly management had the highest annual vacancy rate of 16.2% at Basingstoke and North Hampshire Hospital, whilst endoscopy department showed a 100% vacancy rate at Royal Hampshire County Hospital, although this is based on low numbers (0.1). Multi-sites showed three areas with 100% annual vacancy: cancer management, haemophilia research and development and lymphedema and vascular.

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

**Turnover rates**

From March 2017 to February 2018, the trust reported a turnover rate of 37.4% in medicine, compared to the 12% provisional trust target. A site breakdown can be viewed below:
Basingstoke and North Hampshire Hospital: 37.6%
Royal Hampshire County Hospital: 37.1%

The respiratory department had the highest annual turnover rate of 113.5% at Basingstoke and North Hampshire Hospital, followed by clinical haematology with 61.9%. Dermatology had the highest annual turnover rate at Royal Hampshire County Hospital with 199.2%, followed by McGill ward (acute assessment unit) with 82.2%.

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

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 0.3% in medicine, compared to a 3.5% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 0.4%
- Royal Hampshire County Hospital: 0.0%

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

Bank and locum staff usage

Please note that we are unable to calculate bank and locum usage as a proportion of the total number of shifts available including those covered by permanent staff due to the fact that the trust was unable to provide the total number of available shifts.

The below tables show total shifts filled by bank/locum medical staff from March 2017 to February 2018 in medicine at Hampshire Hospitals NHS Foundation Trust by site; there was no data for how many shifts were not filled:

Basingstoke and North Hampshire Hospital:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by locum staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor in training</td>
<td>472</td>
<td>N/A</td>
</tr>
<tr>
<td>Middle grade</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Consultant</td>
<td>N/A</td>
<td>43</td>
</tr>
<tr>
<td>Total</td>
<td>472</td>
<td>43</td>
</tr>
</tbody>
</table>

Royal Hampshire County Hospital (there were no shifts filled by locum medical staff):

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Shifts filled by bank staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor in training</td>
<td>4</td>
</tr>
<tr>
<td>Middle grade</td>
<td>N/A</td>
</tr>
<tr>
<td>Consultant</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
</tr>
</tbody>
</table>

Multi-site:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by locum staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor in training</td>
<td>137</td>
<td>17</td>
</tr>
<tr>
<td>Middle grade</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Consultant</td>
<td>N/A</td>
<td>896</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>913</td>
</tr>
</tbody>
</table>

The trust stated the wards/areas that have the highest bank or agency usage and current
vacancy rate in medicine were as below, although did not state what this was mainly attributed to:

<table>
<thead>
<tr>
<th>Ward/ area name</th>
<th>Bank Use</th>
<th>Agency Use</th>
<th>Current Vacancy Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unscheduled Care Medical Staff</td>
<td>2.68</td>
<td>5.51</td>
<td>55.68%</td>
</tr>
<tr>
<td>Medical Staff – General Med (BNHH)</td>
<td>1.96</td>
<td>0.00</td>
<td>-6.10%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0.00</td>
<td>1.56</td>
<td>32.32%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.00</td>
<td>1.49</td>
<td>58.48%</td>
</tr>
</tbody>
</table>

The unscheduled care medical staff bank and agency usage and current vacancy rate was across both medicine and urgent and emergency care core services.

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

Staffing skill mix

In December 2017, the proportion of consultant staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust were both about the same as the England average.

Staffing skill mix for the 181 whole time equivalent staff working in medicine at Hampshire Hospitals NHS Foundation 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>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>25%</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 (December 2017)

Andover War Memorial Hospital

The service had enough medical staff to provide the right care and treatment.

On Kingfisher ward there was junior doctor cover 8am to 4pm Monday to Friday. Out of hours cover was provided by the medical registrar at Royal Hampshire County Hospital for advice and admission to a medical ward at the acute hospital, if necessary. Medical staff at Royal Hampshire County Hospital covered the weekend medical on-call.

Basingstoke and North Hampshire Hospital

The service had enough medical staff to provide the right care and treatment.
On the coronary care unit (CCU) two consultants and medical director provided cover and they carried out daily consultant ward rounds during the week. The medical team were on call at the weekend and provided out of hours cover.

At the Candover clinic medical cover was provided 24 hours a day, seven days a week by registered medical officers, there were four in post at the time of inspection.

On F2 and F3 wards there was Monday to Friday consultant cover on site and on-call consultant cover at weekends. During the week daily consultant led ward rounds and involvement in multidisciplinary meetings took place.

Royal Hampshire County Hospital

The service had enough medical staff to provide the right care and treatment.
The duty physician on call was responsible for all new medical patients admitted to the McGill acute medical unit.

The stroke unit had dedicated stroke consultants which included a consultant presence on site between 8am and 6pm. At weekends there were consultants available on site from 9am to 5pm which ensured cover for the hyper-acute stroke unit and followed the thrombolysis pathway which stated a consultant should be on site.

Medical handovers took place daily at 8am. We observed a handover meeting on the stroke unit and in MAU during the inspection and found these were effective and structured. Patients received care which was consultant led and the junior doctors said they were well supported.

We saw that the McGill acute assessment unit had adequate medical staffing at the time of inspection.

Records

Trust wide

The trust used both paper and electronic records. Nursing and current medical records were paper-based. Staff used separate paper folders for medical and nursing notes, including risk assessments. Staff used electronic records to input patient notes about therapy, dementia team, pharmacy and tissue viability nursing notes.

The trust told us they planned to move to fully electronic records for all patient notes in the next year. The process for managing medical records and the availability of patient notes for clinics was on the risk register. However, the risks associated with using both paper and electronic records was not included on the medical division risk register.

Andover War Memorial Hospital

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

During the inspection we reviewed four medical and nursing records

We observed on Kingfisher ward medical paper records were stored in locked trolleys, accessed via a keypad. Staff stored paper nursing records under the lockable trolleys or at the end of patient beds. Storing these records in a defined patient area, minimised the risk of unauthorised access. Staff computers logged out automatically to keep electronic records secure.
Medical records of patients showed medical consultants and junior doctors reviewed patients regularly.

Basingstoke and North Hampshire Hospital

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

We observed paper medical records were stored in locked trolleys, accessible with a keypad system on wards F1, F2, and F3. Paper nursing records were stored under the lockable trolleys or at the end of patient beds. Storing these records in a defined patient area, minimised the risk of unauthorised access. Staff computers logged out automatically to keep electronic records secure.

During the inspection we reviewed 20 medical and nursing records across wards at Basingstoke and North Hampshire hospital. We found records were clear legible and complete.

The trust had a blood glucose monitoring chart staff used for all diabetic patients who were not on intravenous (IV) insulin or pregnant. We reviewed two sets of patient notes for patients with diabetes on F2/F3 wards and found blood glucose monitoring charts were not completed on the day we inspected.

Records did not always contain evidence of clinical decision-making. For example, on the acute assessment unit (AAU) we saw a patient who had been assessed as not at risk of developing pressure areas, had a pressure relieving mattress. The patient record did not include a rationale as to why the patient was on a pressure relieving mattress.

Medical records of patients showed medical consultants and junior doctors reviewed patients regularly.

Royal Hampshire County Hospital

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

During the inspection we reviewed 20 medical and nursing records and Royal Hampshire County Hospital

We observed paper medical records were stored in locked trolleys, accessible with a keypad system on wards we visited. Staff computers logged out automatically to keep electronic records secure.

Medical records of patients showed medical consultants and junior doctors reviewed patients regularly.

Medicines

**Trust wide**

Following the inspection, the trust submitted their standard operating procedure for the management of ward refrigerators, authorised October 2017, for review July 2019. The policy stated minimum and maximum refrigerator temperatures should be recorded daily.

Andover War Memorial Hospital
The service did not have effective processes to manage medicines safely. Staff did not always follow best practice when storing and disposing of medicines.

Medicines were stored securely on Kingfisher ward in a room locked with a keypad. We saw the medicines room was neat, tidy and well-organised. The sample of drugs we checked on Kingfisher ward were all in date. However, we found an open honey dressing had been used and put back on the shelf. We raised this with the ward sister and this was discarded.

On Kingfisher ward we saw the two medicines trolleys were secured and locked to ensure the security of the medications. Medication safety crosses were displayed on the ward that showed there had been no medication errors in March and April 2018. Controlled drugs (CDs) were checked twice a week, staff told us this was on advice from pharmacy. We checked the stock of CDs against what was recorded and signed in the CD register and found the count was correct and signed by two nurses in the CD register.

In the endoscopy service at Andover War Memorial hospital there was an unlocked medicines fridge. The fridge temperatures were not monitored in line with the trust’s policy which stated it should be maintained between 2 and 8 degrees and should be recorded daily. For six days in May 2018 fridge temperatures were not completed. There was no ambient monitoring in treatment room and the red box with resuscitation drugs was not stored securely. This demonstrated that monitoring arrangements to ensure medicines were fit for use were not effective.

Staff were not supported to manage medicines effectively. In the endoscopy service at Andover War Memorial hospital, staff reported there had been no pharmacist input for four months. Despite there being a rota for pharmacist visits, there was no evidence that these visits occurred.

Basingstoke and North Hampshire Hospital

The service did not have effective processes to manage medicines safely. Staff did not always follow best practice when storing, administering and disposing of medicines.

The service had systems in place to ensure medicines were stored securely but we saw that systems were not always followed. Patients own medicines were stored in patients’ rooms or bays within locked patient own ‘pod lockers’ on most wards we visited. However, we were not assured patient’s own medications were stored securely on the acute assessment unit (AAU). On AAU we found two plastic bags, next to the sink, containing patients own medications. The bags held 14 items of prescription medication and eight items of prescription medication respectively and the bags did not contain records for these drugs. Staff we spoke with told us the reason these drugs were in the medicine room was there was no space beside patient trolleys to store drugs securely, and there was not enough room in the medicines cupboard.

Across wards we visited controlled drugs were stored appropriately in secured locked cupboards with the keys held by the nurse in charge.

Staff did not always check the medicine fridge temperatures in line with trust policy. On the acute assessment unit (AAU) we reviewed the fridge temperature checklist and found in May 2018 checks were not completed on 16 days and in April 2018 checks were not completed on ten dates. The fridge temperature checklist did not include guidance on what to do if the fridge temperature was out of range. We asked a nurse what action they would take if the fridge was out of range and they told us they wouldn’t know what to do. This meant there was a risk medicines were stored at the incorrect temperature and therefore would not be safe to use. We saw that on E2 and E3 wards records showed the fridge temperatures had been recorded every day. Storage temperatures were recorded. However, this was only the current temperatures. Maximum and
Minimum fridge temperatures were not monitored to ensure medicines remained within a safe temperature range.

Systems for management of pharmacy stock were not effective. We found medicines were passed the expiry date stored in the AAU treatment room. The AAU treatment room contained eight items of out of date medicine.

Wards had access to some medicines in kits, for example for the treatment of allergic reactions and for diabetic emergencies. However, staff did not check the contents of the kits regularly to ensure they were always suitable for use.

Nurses administered medicines in a safe manner in line with national guidance. We observed medicines rounds on E4 and on the acute assessment unit. Nurses wore red aprons to identify staff they were not to be disturbed whilst administering medicines. The nurses recorded medicines given on an electronic system. We saw the medicines trolley was secured with an access restricted code. However, we spoke with three members of staff and they were not aware of how often this code was changed. The medicines trolley included patient’s own medicines and staff access other drugs from stock cupboard.

On the acute assessment unit and E3 ward we checked log books for controlled drugs and found they were completed correctly. However, on E3 ward we found a patient’s own medicine (Fludrocortisone) in the fridge when the patient had been discharged. On E3 ward we found patient’s own controlled drugs for three patients were stored in the medicines fridge after they had been discharged from the ward.

Staff access to pharmacy support on wards was mixed. On AAU the clinical matron told us the pharmacist does medicines reconciliation every day. However, other clinical matrons we spoke with reported there was a lack of pharmacy support for nursing staff on the wards. The clinical matron of F2 and F3 wards told us problems with delays to ‘to take out’ (TTO) drugs were frequent and they did not report this as an incident as delays happened very regularly.

We saw oxygen cylinders were stored securely, upright and chained to the wall, at Candover clinic.

We were not assured medicines were always disposed of safely in line with trust policy. In the acute assessment unit medicines room, we found a seven litre sharps waste bin was dated 12 June 2018. We saw the sharps bin was half full of drugs, insulin ampoules, cannulas, needles, a pair of scissors and bottles of drugs. This was unsafe disposal of medicines as medicines should be disposed of in a separate disposal box rather than a sharps bin.

Royal Hampshire County Hospital

The service did not have effective processes to manage medicines safely. Staff did not always follow best practice when storing, administering and disposing of medicines.

The service had systems in place to ensure medicines were stored securely. Patients own medicines were stored in patients’ rooms or bays within locked patient own ‘pod lockers.’ Controlled drugs were stored appropriately in secured locked cupboards with the keys held by the nurse in charge. For example, we saw controlled drugs were stored securely on Shawford ward. We checked the controlled drugs log book on Shawford ward and found it was fully completed.

On McGill acute assessment unit, we carried out a random check of the medicines fridge and found eight items of out of dates solutions which included two bottles of antiseptics and four bottles of fluids for cleaning surgical instruments.
Staff did not always check the medicine fridge temperatures in line with trust policy. For example, on the McGill acute assessment unit we reviewed the fridge temperature checklists and found in June 2018 one date had not been checked, in May 2018 one date had not been checked and in April 2019 three dates had not been checked.

We reviewed medicines stored on Shawford ward and found all items were in date for safe use. Wards had access to some medicines in kits, for example for the treatment of allergic reactions and for diabetic emergencies. However, staff did not check the contents of the kits regularly to ensure they were always suitable for use.

We saw that medicines were dispensed safely. We observed the medicines administration round on Wykeham ward. The nurse identified patients using their identity bracelet, checking their name, hospital number and date of birth against the drug chart. The nurse verbally confirmed the name and date of birth with each patient. We saw the medication trolley was secured to the wall and locked when not in use.

We saw on Shawford ward nurses monitored and reported missed doses and reasons why doses were missed every day. The clinical matron explained this could be patient asleep or patient refused, but they would follow up with staff if the reason given was ‘drug not available’ or ‘last drug given late’. There had been an increase in missed doses because one member of staff did not know where the eye drops were stored.

Systems for management of pharmacy stock were not effective. In the McGill acute assessment unit store room, we found two items of out of date stock.

Incidents

Trust wide

We reviewed the incidents for the medical service reported to through the electronic reporting system between April 2017 and March 2018. The medical services division reported 44,031 incidents between April 2017 and March 2018. Of these 55,249 were graded as no harm, 24,087 were low harm, 383 resulted in moderate harm, or severe harm and 313 were severe harm. Slips trips and falls were the most common form of serious incident (76% of serious incidents)

The duty of candour is a regulatory duty that relates to openness and transparency. It requires the 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 the last two duty of candour response letters the trust had sent to patients following serious incidents. We saw the trust apologised to patients and informed them of the outcome of the investigation of the incident. The trust also asked patients if they would like to receive a copy of the full investigation report.

The medical division did mortality and morbidity reviews. We reviewed the minutes for the mortality and morbidity meetings for the past year. The minutes showed evidence of learning and action taken forward.

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 April 2017 to March 2018, the trust reported no incidents classified as never events for medicine.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 21 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England where the incident occurred between April 2017 and March 2018.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 16 (76% of total incidents).
- Pressure ulcer meeting SI criteria with two (10% of total incidents).
- Medication incident meeting SI criteria with one (5% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (5% of total incidents).
- Treatment delay meeting SI criteria with one (5% of total incidents).

(Source: Strategic Executive Information System (STEIS))

We reviewed the last three recent serious incident investigation reports and saw evidence of learning was identified and action plans developed. For example, to improve compliance with falls awareness training and completion of falls risk assessments and care plans.

The service reviewed serious incidents at a monthly serious event review group meeting. Learning from serious incidents was shared every month following the serious event review group, the midweek message and ‘in touch’ as well as the divisional governance structures.

**Andover War Memorial Hospital**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Staff were aware of how to report incidents through the trust electronic reporting system. Staff told us they had debrief sessions after patient falls. We saw the endoscopy service had an incident report folder it showed staff had received a debrief following an incident where a patient had been abusive to staff.

Staff could describe learning from recent incidents. For example, a nurse told us how staff were reminded to call an ambulance if they think it is clinically necessary after an incident.
**Basingstoke and North Hampshire Hospital**

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 were aware of how to report incidents through the trust electronic reporting system. Staff gave examples of incidents they had reported, for example patient falls. Staff told us they had debrief sessions after patient falls. Staff demonstrated good awareness of precautions to prevent patient falls such as the use of falls alarms and low-rise beds.

Staff on F1 ward were aware of medication errors

Staff we spoke with told us delays to patient discharge due to internal delays in arranging ‘to take out’ (TTO) drugs.

Staff were aware of how to report incidents through the trust electronic reporting system. For example, staff had reported medication errors, patient slips and falls. Staff we spoke with said they were encouraged to report incidents. Staff received feedback from incidents during safety huddles, handovers and on a one to one basis.

Learning from incidents was shared in ward meetings. For example, on E4 learning from incidents was included in the minutes of monthly ward meeting. A reminder was included that nurses must write notes in line with nursing and midwifery council (NMC) guidelines. We saw learning from a recent fall was shared with staff through the Shawford ward newsletter in March 2018.

Clinical matrons we spoke with were aware of their responsibilities under duty of candour.

**Royal Hampshire County Hospital**

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 were aware of how to report incidents through the trust electronic reporting system. Staff told us they had debrief sessions after patient falls.

The hospital shared learning from incidents through daily safety huddles, a shared learning page on the trust intranet and team meetings.

**Safety thermometer**

**Trust wide**

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 45 new pressure ulcers, 28 falls with harm and 29 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at, falls with harm and new urinary tract infections at Hampshire Hospitals NHS Foundation Trust

Total Pressure ulcers (45)

Total Falls (28)

Total CUTIs (29)

(Source: Safety Thermometer)

The May 2018 safer staffing report to the board of directors included a trust wide analysis of safety thermometer results.

We requested any action plans relating to safety thermometer audits but the trust did not submit any formal plans. Ward meeting minutes showed that safety thermometer results were discussed.

Andover War Memorial Hospital

The service used safety monitoring results well. Staff collected safety information and managers used this information to improve the service. However, the results were not always displayed for patients and visitors to see.

The safety thermometer was not displayed on Kingfisher ward.

Basingstoke and North Hampshire Hospital

The service used safety monitoring results well. Staff collected safety information and managers used this information to improve the service. However, the results were not always displayed for patients and visitors to see.
The safety thermometer was not consistently displayed in all wards. Most wards displayed planned and actual staffing levels. We saw on wards F2 and F3 safety thermometer data was included in the ward meeting minutes for June 2018 to show staff how the ward was performing and encourage improvement. The safety thermometer was displayed on the acute assessment unit.

A board with information regarding patient safety was displayed on F1 on 13 June 2018 information displayed showed it was 219 days since the last pressure ulcer and one day since the last patient fall. The clinical matron told us the statistics were used to encourage improvement in providing harm free care.

**Royal Hampshire County Hospital**

The service used safety monitoring results well. Staff collected safety information and managers used this information to improve the service.

The safety thermometer was consistently displayed outside all the wards we visited.

Shawford ward had recently introduced a ward newsletter since March 2018. The newsletter included recent audit results in relation to pressure ulcers and falls.

**Is the service effective?**

**Evidence-based care and treatment**

**Trust wide**

Andover War Memorial Hospital and Basingstoke and North Hampshire Hospital were JAG accredited at the time of the inspection. JAG is a quality improvement and service accreditation programme for gastrointestinal endoscopy. They assess endoscopy services to monitor whether they meet and maintain the JAG quality standards However, the endoscopy service at Royal Hampshire County hospital was not JAG accredited at the time of inspection. JAG accreditation was withdrawn from the trust endoscopy services in October 2015. The service was in the process of applying for re-accreditation. This meant the endoscopy service met the national guidance for delivering an endoscopy service, which included routine auditing of the service provided. We spoke with the clinical and operational service lead for endoscopy and they were clear what changes were needed to decontamination and privacy to meet the JAG guidelines.

**Andover War Memorial Hospital**

The service provided care and treatment based on national guidance. Policies and procedures in endoscopy had not been reviewed in line with the trust’s policy.

The medical division had pathways and protocols for a range of conditions, which took into account national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. For example, falls and pressure ulcer prevention and sepsis pathways.

On Kingfisher ward staff were aware of how to access clinical policies through the trust intranet.

We found ten out of 14 endoscopy standard operating procedures we checked were out of date.

Whilst the endoscopy service was JAG accredited, practice we observed relating to management of mixed sex environment did not meet JAG standards.

**Basingstoke and North Hampshire Hospital**
The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The medical division had pathways and protocols for a range of conditions, which took into account national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. For example, heart failure, diabetes, respiratory conditions, falls and pressure ulcer prevention and sepsis pathways.

Staff had access to local and national guidelines through the trust’s intranet. For example, on the coronary care unit we saw staff had access to NICE guidelines on chest pain and heart failure. For example, NICE clinical guideline 167 myocardial infarction with ST-segment elevation: acute management and NICE clinical guideline 94 unstable angina and NSTEMI: early management.

In line with national guidelines, patient records on the acute assessment unit (AAU) showed they were seen and reviewed by a consultant twice daily. Once transferred to a general ward, records we reviewed showed, in line with national guidelines, most patients were reviewed during a consultant led ward round every 24 hours.

On AAU we saw evidence in a patient’s medical records that NICE guidance for alcohol withdrawal was followed. Patient records showed the patient was seen by the alcohol liaison nurse, on treatment, discussed at MDT.

We saw from the minutes of E1 March 2018 ward meeting staff were reminded to read updated gastroenterology policies and checklists.

Royal Hampshire County Hospital

The service provided care and treatment based on national guidance and evidence. Managers checked to make sure staff followed guidance.

The medical division had pathways and protocols for a range of conditions, which took into account national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. For example, heart failure, stroke, diabetes, respiratory conditions, falls and pressure ulcer prevention and sepsis pathways.

We saw staff had access to local and national guidelines through the trust’s intranet and staff we spoke with were aware of how to access them.

On Twyford ward which was a designated stroke unit, staff followed NICE guidelines for feeding protocols. Other guidelines staff followed included thrombolysis treatment of patients following acute stroke and venous thrombolysis(VTE).

In line with national guidelines, patient records on the acute assessment unit (AAU) showed they were seen and reviewed by a consultant twice daily. Once transferred to a general ward, records we reviewed showed, in line with national guidelines, most patients were reviewed during a consultant led ward round every 24 hours.

The endoscopy service was not JAG accredited at the time of inspection. The service was in the process of re-submitting this following improvement to decontamination processes and mixed sex facilities.

Endoscopy staff followed the procedures for assessing and booking patients in line with British Society of Gastroenterology (BSG) guidance. This meant that enough time was given for procedures and results were shared with patients in a timely manner.
Staff in endoscopy were not always using the most up to date policies. The Entonox checklist ‘Patient suitability for administering Entonox’ we saw in a patient record was due for review 26 March 2016 but was still in use.

Nutrition and hydration
Andover War Memorial Hospital
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 could cater for patients’ religious, cultural and other preferences.
Staff assessed patients’ nutritional status using a validated screening tool, the malnutrition universal screening tool (MUST), within 24 hours of admission. This allowed staff to identify and minimise the risk of malnutrition by ensuring they received adequate food and fluids.
We found nutritional risk assessments were completed in the patients’ notes we reviewed.
Andover War Memorial had protected mealtimes. This meant the maximum number of staff were available to help and allowed patients to eat without distraction. The ward sister told us family members of patients living with dementia were encouraged to come in and help patients eat. Staff encouraged patients to eat in the day room.
At Andover War Memorial hospital, we observed an activity co-ordinator serving a choice of cake, scones and jam to patients as an afternoon snacks. Sugar-free options were available for diabetic patients.
Patients we spoke with were positive about the food on offer.
The patient-led assessment of the care environment (PLACE) in the interim 2018 report stated the Andover War Memorial hospital scored 92.14% for ward food.

Basingstoke and North Hampshire Hospital
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 could cater for patients’ religious, cultural and other preferences.
Staff assessed patients’ nutritional status using a validated screening tool, the malnutrition universal screening tool (MUST), within 24 hours of admission. This allowed staff to identify and minimise the risk of malnutrition by ensuring they received adequate food and fluids.
Staff offered patients three main meals a day and snacks were available if needed. There was a choice of food available and the hospital could cater for cultural, religious and therapeutic diets.
The service audited compliance with completion of MUST scores. On E4 we saw the MUST audit was displayed on the ward - weight recorded 91%, height recorded 78%, within 24 hours 76%, weekly 90%, errors 5/72, overall 87%.
We found nutritional risk assessments were completed in the patients’ notes we reviewed.
We observed the lunch service on F2 and F3 wards and saw staff used the ‘red tray’ system to identify patients who needed support with eating. Staff offered patients hand cleaning wipes before they ate. We saw a healthcare assistant sitting with a patient and interacting with them in a friendly manner whilst supporting them to eat. We saw staff encouraged patients to eat together. For
example, on F2 ward two patients ate together in the ‘sunflower suite’ with the activities co-ordinator.

The patient-led assessment of the care environment (PLACE) in the interim 2018 report stated Basingstoke and North Hampshire Hospital scored 92% for ward food.

Royal Hampshire County Hospital

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 could cater for patients’ religious, cultural and other preferences.

Staff assessed patients’ nutritional status using a validated screening tool, the malnutrition universal screening tool (MUST), within 24 hours of admission. This allowed staff to identify and minimise the risk of malnutrition by ensuring they received adequate food and fluids.

Staff offered patients three main meals a day and snacks were available if needed. We saw patients were offered a hot drink and a biscuit following endoscopy procedure. There was a choice of food available and the hospital could cater for cultural, religious and therapeutic diets.

On Wykeham ward we observed a nurse thickening a patient’s drink appropriately for a patient who had swallowing difficulties. We saw that the patient had been referred to a speech and language therapist for a formal assessment.

We reviewed five nutritional risk assessments and found these were competed in Twyford ward.

On Twyford, the hyper acute stroke unit, dietitians were available to offer advice and support for patients on nasogastric tube feeding.

In the discharge lounge we saw patients waiting to be discharged had access to drinks and the nurse could arrange meals from the kitchen if they were waiting over a meal time.

Staff used the ‘red tray’ system to identify people who needed assistance to eat. We saw that all wards had protected meal times. This meant the maximum number of staff were available to help and allowed patients to eat without distraction.

The patient-led assessment of the care environment (PLACE) in the interim 2018 report scored Royal Hampshire County Hospital 89 % for ward food.

Pain relief

Andover War Memorial Hospital

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.

Staff used a numerical score to measure pain experience by patients. If a patient was unable to communicate verbally, for example a stroke patient or someone living with advanced dementia, medical therapy and nursing staff considered the patient’s body language to determine the level of pain they were experiencing. For people living with dementia, the Abbey Pain Scale, a visual pain measurement tool was used.

We saw evidence in patients’ nursing records the Abbey Pain Scale was used to assess pain. Pain assessments were recorded on the patient national early warning score (NEWS) chart and nurses checked patient’s pain levels during routine observations.
Patients we spoke with said they received pain relief promptly at night if they rang their call bell.

Basingstoke and North Hampshire Hospital

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.

Staff used a numerical score to measure pain experience by patients. If a patient was unable to communicate verbally, for example a stroke patient or someone living with advanced dementia, medical therapy and nursing staff considered the patient’s body language to determine the level of pain they were experiencing. For people living with dementia, the Abbey Pain Scale, a visual pain measurement tool was used.

We saw evidence in patients’ nursing records the Abbey Pain Scale was used to assess pain. Pain assessments were recorded on the patient national early warning score (NEWS) chart and nurses checked patient’s pain levels during routine observations.

On the AAU we observed a patient complaining of pain on the side of their body. Nursing staff responded promptly to the patient and gave the patient pain relief.

Most patients we spoke with told us they received pain relief when they needed it. However, a patient we spoke with on E4 ward told us they were not offered pain relief when they arrived on the ward from the acute assessment unit. The patient had to get a relative to follow up their request for pain relief with nursing staff.

Royal Hampshire County Hospital

Staff assessed and monitored patients regularly to see if they were in pain. However, tools used to assess pain for people who could not communicate were not consistently used.

Staff used a numerical score to measure pain experience by patients. If a patient was unable to communicate verbally, for example a stroke patient or someone living with advanced dementia, medical therapy and nursing staff considered the patient’s body language to determine the level of pain they were experiencing. For people living with dementia, the Abbey Pain Scale, a visual pain measurement tool was used.

We saw evidence in patients’ nursing records the Abbey Pain Scale was used to assess pain. Pain assessments were recorded on the patient national early warning score (NEWS) chart and carried out during routine observations.

However, on Freshfield ward, in two records for patients living with dementia, it was recorded that they had been assessed as having no pain but there was no evidence of what tool was used to assess non-verbal signs of pain.

Patients we spoke with told us they received pain relief when they needed it.

Patient outcomes

Trust wide medical services audits

Medical services took part in several national audits, which are described below.
Heart Failure Audit

In-hospital Care Scores

Results for both Basingstoke and North Hampshire Hospital and Royal Hampshire County Hospital in the 2016 Heart Failure Audit were better than the England and Wales average for three of the four standards relating to in-hospital care. However, it was worse for the remaining metric (input from a specialist).

Discharge Scores

Results for both hospitals were worse than the England and Wales average for five of the nine standards relating to discharge and similar or better for the remaining four measures.
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.

Royal Hampshire County Hospital

The 2017 National Diabetes Inpatient Audit identified 68 in-patients with diabetes at Royal Hampshire County Hospital. 88.1% 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 3.

- On average no consultant hours per week were spent with patients in 2017, which places this site in quartile 1, compared with quartile 3 in 2016.
- 100% of patients with diabetes received a diabetic foot risk assessment within 24 hours of admission, which places this site in quartile 4, which was the same as in 2016.
- 96.6% of patients with diabetes were visited by a member of the diabetes team, which places this site in quartile 4, which was the same quartile as in 2016.
- 8% of patients with diabetes experienced at least one glucose management error, which places this site in quartile 1, which was the same quartile as in 2016.
- 76.2% of patients with diabetes reported that the timing of their meals was always or almost always suitable, which places this site in quartile 4, compared to quartile 3 in 2016.
- 73.9% of patients with diabetes reported that all or most of the staff caring for them were aware that they had diabetes, which places this site in quartile 1, compared to quartile 3 in 2016.
- 93.2% of patients with diabetes reported that staff were definitely, or to some extent, able to answer their questions in a way that they understood, which places this site in quartile 4, compared to quartile 3 in 2016.

Basingstoke and North Hampshire Hospital

The 2017 National Diabetes Inpatient Audit identified 72 inpatients with diabetes at Basingstoke and North Hampshire Hospital; 75.4% 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 1.

- On average 0.52 consultant hours per week were spent with patients in 2017, which places this site in quartile 4 compared to quartile 3 in 2016.
- 100% of patients with diabetes received a diabetic foot risk assessment within 24 hours of admission, which places this site in quartile 4, which was an improvement from 2016 when the site scored 50%.
- 48.6% of patients with diabetes were visited by a member of the diabetes team, which places this site in quartile 4, the same as in 2016.
- 18.4% of patients with diabetes experienced at least one glucose management error, which places this site in quartile 3, compared with quartile 2 in 2016.
- 56.6% of patients with diabetes reported that the timing of their meals was always or almost always suitable, which places this site in quartile 2, compared with quartile 3 in 2016.
- 79.4% of patients with diabetes reported that all or most of the staff caring for them were aware that they had diabetes, which places this site in quartile 2, the same as in 2016.
• 71.2% of patients with diabetes reported that staff were definitely, or to some extent, able to answer their questions in a way that they understood, which places this site in quartile 1, compared to quartile 4 in 2016
(Source: National Diabetes Inpatient August 2017)

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, 25.5% of nSTEMI patients at Basingstoke and North Hampshire Hospital and 0% at Royal Hampshire County Hospital were admitted to a cardiac unit or ward compared to the England average of 55.8%.

99.7% of nSTEMI patients at Basingstoke and North Hampshire Hospital and 97.9% at Royal Hampshire County Hospital were seen by a cardiologist or member of the team compared to an England average of 96.2%.

The proportion of nSTEMI patients who were referred for or had angiography was 78.1% at Basingstoke and North Hampshire Hospital and 49.6% at Royal Hampshire County Hospital compared to an England average of 83.6%.

<table>
<thead>
<tr>
<th>2015/16</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography</th>
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</thead>
<tbody>
<tr>
<td>Basingstoke and North Hampshire Hospital</td>
<td>310</td>
<td>310</td>
<td>306</td>
</tr>
<tr>
<td></td>
<td>99.7%</td>
<td>25.5%</td>
<td>78.1%</td>
</tr>
<tr>
<td>Royal Hampshire County Hospital</td>
<td>131</td>
<td>131</td>
<td>127</td>
</tr>
<tr>
<td></td>
<td>97.9%</td>
<td>0%</td>
<td>49.6%</td>
</tr>
<tr>
<td>England: overall</td>
<td>47,039</td>
<td>47,039</td>
<td>39,082</td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

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

We saw that performance against non-STEMI performance was reviewed at the cardiology clinical governance meetings.

National Lung Cancer Audit

The trust took part in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 50.6%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 38.1%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 22.1%. This is within expected range compared to the national level. The 2016 figure was not significantly different from the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 59.2%. This is within expected range compared to the national level. The 2016 figure was not significantly different from the national level.
The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 65.1%. This is within expected range compared to the national level. The 2016 figure was not significantly different from the national level.

The one-year relative survival rate for the trust in 2017 is 40.9%. This is within expected range compared to the national level. The 2016 figure was not significantly different from the national level.

(Source: National Lung Cancer Audit 2017)

National Audit of Inpatient Falls 2017

The trust took part in the 2017 National Audit of Inpatient Falls and the crude proportion of patients who had a vision assessment (if applicable) was 85%. 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 14%. 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 12%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 75%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust had developed an action plan following the 2017 falls audit. The action plan included developing a falls audit programme, improving delirium screening on admission and improved delirium care planning. The falls prevention strategy was reviewed as part of the patient safety group. The patient safety group was set up in April 2018, a few months before our inspection so we were unable to assess its effectiveness.

Trust level relative risk of readmission

From December 2016 to November 2017, patients at the trust had a similar to expected risk of both readmission for elective admissions and of readmission for non-elective admissions when compared to the England averages.

Elective admissions:

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in cardiology had a lower than expected risk of readmission for elective admissions

Elective Admissions – Trust Level
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 represents the opposite. Top three specialties for specific trust based on count of activity.

Non-elective admissions:

- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a similar to expected risk of readmission for non-elective admissions

Non-elective Admissions – Trust Level

Andover War Memorial Hospital

Managers monitored the effectiveness of care and treatment and used the findings to improve the care and treatment patients received. They compared local results with those of other services in the trust to learn from them.

Relative risk of readmission at Andover War Memorial Hospital

From December 2016 to November 2017, patients at Andover War Memorial Hospital had a lower than expected risk of readmission for elective admissions and a higher to expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions:

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in dermatology had a lower than expected risk of readmission for elective admissions

Elective Admissions – Andover War Memorial 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 represents the opposite. Top three specialties for specific trust based on count of activity.

Non-elective admissions:

- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions

Non-Elective Admissions – Andover War Memorial 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 represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: HES – Readmissions (December 2016 – November 2017))

Basingstoke and North Hampshire Hospital

Relative risk of readmission at Basingstoke and North Hampshire Hospital -
From December 2016 to November 2017, patients at Basingstoke and North Hampshire Hospital had a similar to expected risk of both readmission for elective admissions and of readmission for non-elective admissions when compared to the England averages.

Elective admissions:

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

Elective Admissions – Basingstoke and North Hampshire 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 represents the opposite. Top three specialties for specific trust based on count of activity.
Non-elective admission:
- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a similar to expected risk of readmission for non-elective admissions

Non-Elective Admissions – Basingstoke and North Hampshire Hospital

![Graph showing readmission rates for different specialties.]

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 represents the opposite. Top three specialties for specific trust based on count of activity.

The trust audited patient outcomes as part of the PJ paralysis campaign. On E4 ward between 17 April and 21 May 2018 238 patients were dressed in day clothes, 20 patients on HDU, 185 on F2 ward and 32 on F2 ward.

(Source: HES - Readmissions (December 2016 – November 2017))

Royal Hampshire County Hospital

Relative risk of readmission at Royal Hampshire County Hospital
From December 2016 to November 2017, patients at Royal Hampshire County Hospital had a similar to expected risk of both readmission for elective admissions and of readmission for non-elective admissions when compared to the England average.

Elective admissions:
- Patients in medical oncology had a similar to expected risk of readmission for elective admissions
- 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

Elective Admissions – Royal Hampshire County Hospital

![Graph showing readmission rates for different specialties.]

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 represents the opposite. Top three specialties for specific trust based on count of activity.
Non-elective admissions:
- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in stroke medicine had a similar to expected risk of readmission for non-elective admissions

**Non-elective Admissions – Royal Hampshire County Hospital**

![Graph showing non-elective admissions by specialty]

*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 represents the opposite. Top three specialties for specific trust based on count of activity.*

(Source: HES - Readmissions (December 2016 – November 2017))

**Sentinel Stroke National Audit Programme (SSNAP)**

Royal Hampshire County 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 A in the latest audit, April 2017 to July 2017, which was an improvement from the previous audit, December 2016 to March 2017, where the hospital achieved grade B.

**Royal Hampshire County Hospital**

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan 16 – Mar 16</th>
<th>Apr 16 – Jul 16</th>
<th>Apr 16 – Nov 16</th>
<th>Dec 16 – Mar 17</th>
<th>Apr 17 – Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

*Best A B C D E Worst N/A No assessment*

- The combined total key indicator level has seen an improvement in performance from grade B to grade A in the latest audit.

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C</td>
<td>D↓</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B↑</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>
Domain 2: Stroke unit has seen an improvement from grade C to grade B in the latest audit for both patient and team centred performance.

Domain 3: Thrombolysis has seen an improvement from grade C to grade B in the latest audit for team centred performance.

Domain 6: Physiotherapy has seen a decline in performance from grade A to grade B in the latest audit for both patient and team cent centred performance.

Domain 7: Speech and language therapy has seen an improvement from grade C to grade B in the latest audit for both patient and team centred performance.

Domain 9: Standards by discharge has seen an improvement from grade C to grade B in the latest audit for both patient and team centred performance.

Both patient-centred and team centred total key indicator levels have improved from grade B to grade A in the latest audit.

(Source: Royal College of Physicians London, SSNAP audit)

Staff on the hyper acute stroke unit, Twyford ward at Royal Hampshire County Hospital said patients received thrombolysis treatment in the accident and emergency department and were
transferred to the hyper acute stroke unit for intensive monitoring and completion of this treatment.

The trust monitored performance in the Sentinel Stroke National Audit programme (SSNAP) audit as part of the medicine divisional board report. The following performance indicators relating to stroke were included in the medicine divisional board report –

- % of stroke patients that spend 90% of time on the stroke ward – January 2017 to January 2018 the trust met their target of 80% in 11 out of 12 months.
- % high risk TIA patients seen and treated within 24 hours of first health professional assessment - January 2017 to January 2018 the trust met their target of 60% in eight out of 12 months.
- % high risk TIA patients seen and treated within 24 hours of first health professional assessment including patient choice/referral delays – January 2017 to January 2018 the trust met their target of 85% in nine out of 12 months.
- % direct admissions to the stroke unit - January 2017 to January 2018 the trust scored below 80% in seven out of 12 months, there was no trust target for this indicator.

Competent staff

Andover War Memorial Hospital

There was an appraisal process in place and staff had received appraisal of their work.

Appraisal rates at Andover War Memorial Hospital:

From April 2017 to February 2018, 85% of staff at Andover War Memorial Hospital had received an appraisal compared to a trust target of 80% for non-medical staff and 90% for medical staff.

<table>
<thead>
<tr>
<th>Staffing groups</th>
<th>Number completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>10</td>
<td>14</td>
<td>71.4%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>34</td>
<td>40</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

Nursing staff at Andover War Memorial Hospital had a completion rate of 71.4%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff we spoke with were positive about the monthly ‘lunch and learn’ sessions.

Nurse endoscopists completed an interventional competency workbook to ensure they were competent in their role.

The trust used volunteers on medical wards and in the dementia team to support patients by engaging in social activities. Volunteers were trained and supported to carry out their role.

Basingstoke and North Hampshire Hospital

There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. Appraisal rates for all staff were below the
trust target.

Appraisal rates at Basingstoke and North Hampshire Hospital:

From April 2017 to February 2018, 49.2% of staff within medicine at Basingstoke and North Hampshire Hospital had received an appraisal compared to a trust target of 80% for non-medical staff and 90% for medical staff.

Basingstoke and North Hampshire Hospital

<table>
<thead>
<tr>
<th>Staffing groups</th>
<th>Number completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>15</td>
<td>21</td>
<td>71.4%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff – Hospital</td>
<td>33</td>
<td>55</td>
<td>60.0%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>51</td>
<td>85</td>
<td>60.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>26</td>
<td>52</td>
<td>50.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>115</td>
<td>242</td>
<td>47.5%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>115</td>
<td>275</td>
<td>41.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>369</strong></td>
<td><strong>750</strong></td>
<td><strong>49.2%</strong></td>
</tr>
</tbody>
</table>

Medical/dental staff at Basingstoke and North Hampshire Hospital had a completion rate of 60%, whilst 47.5% of nursing staff had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

All new staff had to complete a mandatory trust-wide induction. Staff we spoke with who had recently joined the trust told us they had received an induction to the ward they were working on as well as trust wide induction. Temporary staff confirmed they had received an induction to the ward on their first shift.

Staff we spoke with in specialist areas told us about additional training they had done to ensure they were competent. We requested compliance with non-mandatory training courses for staff working at Basingstoke and North Hampshire Hospital. For staff on cardiology, respiratory, and gastroenterology wards was IV infusion training above 90%. For staff on cardiology and respiratory NIV training compliance was 47.61% and 81.25%. Data showed 72.7% of nursing staff on the gastroenterology ward had completed training in flushing biliary drains and liver drains.

Nurse endoscopists completed an interventional competency workbook to ensure they were competent in their role.

Health care assistants working in the acute assessment unit (AAU) had all received higher level competency training to enable them to meet the needs of higher acuity patients in the unit. We requested the competency framework and saw the framework included training in use of the national early warning score (NEWS), falls risk assessments and blood glucose checks.

Staff we spoke with were positive about development opportunities in the trust. Staff told us they found the appraisal process useful. Staff had access to development opportunities. For example, nursing associates we spoke with said they felt well supported by the trust and had enough time to study.

Staff we spoke with told us they had regular one to one meetings with their line manager and found their manager was supportive.
The trust did not monitor nurse clinical supervision centrally. The trust told us band 7 nurses met monthly for a meeting that included peer group clinical supervision.

Doctors we spoke with said they had good support from consultants and access to learning opportunities in the trust.

Staff communication folders were used to share learning. For example, we saw the June 2018 F2 and F3 ward meeting minutes included updates for sharing staff learning included details of a study day on moisture-related skin damage and pressure ulcers.

The trust did not have a clinical educator role. A clinical matron we spoke with acknowledged that this was a gap in provision and was in conversation with the chief nurse about introducing a clinical educator role.

The trust used volunteers on medical wards and in the dementia team to support patients by engaging in social activities. Volunteers were trained and supported to carry out their role.

Royal Hampshire County Hospital

There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. Appraisal rates for all staff were below the trust target.

Appraisal rates at Royal Hampshire County Hospital

From April 2017 to February 2018, 46.8% of staff at Royal Hampshire County Hospital had received an appraisal compared to a trust target of 80% for non-medical staff and 90% for medical staff.

<table>
<thead>
<tr>
<th>Staffing groups</th>
<th>Number completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff – Hospital</td>
<td>16</td>
<td>21</td>
<td>76.2%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>23</td>
<td>40</td>
<td>57.5%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>35</td>
<td>68</td>
<td>51.5%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>114</td>
<td>248</td>
<td>46.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
<td>18</td>
<td>44.4%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>92</td>
<td>222</td>
<td>41.4%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>292</strong></td>
<td><strong>624</strong></td>
<td><strong>46.8%</strong></td>
</tr>
</tbody>
</table>

Medical/dental staff at Royal Hampshire County Hospital had a completion rate of 76.2%, whilst 41.4% of nursing staff had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

All new staff had to complete a mandatory trust-wide induction. Staff we spoke with who had recently joined the trust told us they had received an induction to the ward they were working on.
as well as trust wide induction. Temporary staff confirmed they had received an induction to the ward on their first shift.

Staff we spoke with in specialist areas told us about additional training they had done to ensure they were competent. We requested staff compliance with non-mandatory training courses for staff working at Royal Hampshire County Hospital. For staff on cardiology, respiratory, and gastroenterology wards was IV infusion training was between 78.5% and 87.5%. For staff on cardiology staff NIV training compliance was 21.42% and respiratory ward training compliance was 93.75%. Data showed 90.9% of staff on Twyford stroke unit had received stroke training. Data showed 81.8% of nursing staff on the gastroenterology ward had completed training in flushing biliary drains and liver drains.

Twyford ward had an away day to simulate scenarios regarding difficult and challenging patients where staff can practice how to deal with these situations in a safe environment. This had been arranged over four dates so everyone in the team could attend

Nurse endoscopists completed an interventional competency workbook to ensure they were competent in their role.

On the endoscopy service patients had access to a range of specialist nurses including irritable bowel disease clinical nurse specialists and nutrition clinical nurse specialists.

Staff had access to development opportunities. For example, a dementia coordinator we spoke with had been supported by the trust to do a level three NVQ health and social care apprenticeship.

The trust used volunteers on medical wards and in the dementia team to support patients by engaging in social activities. Volunteers were trained and supported to carry out their role.

Multidisciplinary working

Andover War Memorial Hospital

Staff worked well together for the benefit of patients.

A doctor we spoke with was positive about the multidisciplinary working on Kingfisher ward. Staff told us there was a good working rapport between all staff working within the endoscopy service and the wider hospital site. We saw evidence of this during our inspection. All staff regardless on grade or role had helpful, friendly and professional interactions with each other.

Access to pharmacy support and the resuscitation team was via the RHCH site at Winchester. During our inspection we saw evidence and heard from staff that they did not always receive the support they felt they needed. For example, we were told by nursing staff that there had been no visits by the pharmacy team for the past four months due to staff shortages, despite there being a pharmacy rota for the hospital site.

Basingstoke and North Hampshire Hospital

Staff worked well together for the benefit of patients.

Staff on medical wards had regular multidisciplinary meetings to discuss patient care. We observed the morning multidisciplinary meeting on F1 ward. A consultant, doctors, the ward sister, a
physiotherapist and a patient flow coordinator attended the meeting. We saw effective collaborative decision making to support safe patient discharges. Staff reviewed estimated dates of discharge at the meeting. The discussions of the meeting were recorded in patient’s electronic records.

We attended the morning multidisciplinary meeting on the acute assessment unit (AAU). The meeting was attended by consultants, senior house officers (SHOs), a pharmacist, a member of the critical care in-reach team, a physiotherapist and the ward manager. We saw excellent engagement and good working relationships. We saw good joint-working with the palliative care team and saw that staff worked together to arrange for a patient at end-of-life to transfer to a ward.

In cardiology we saw therapy staff worked well with nursing staff and attended multidisciplinary meetings three times a week.

A patient we spoke with on the acute assessment unit was positive about the way staff worked together and told us, ‘staff appear very dynamic and a well gelled team that know what they have to do.’

Staff reported they had good working relationships, for example, with the critical care outreach team. Doctors we spoke with were positive about the communication between different teams.

Staff could arrange local voluntary services to support elderly patients when returning home from hospital. Local voluntary services supported older patients on returning home by arranging befriending or support with food shopping.

Nursing staff worked with local mental health teams, social care and care at home support agencies where appropriate. Information was shared when necessary, although this was sometimes difficult due to differences in record keeping between different providers.

Royal Hampshire County Hospital

Staff worked well together for the benefit of patients.

Staff on medical wards had regular multidisciplinary meetings to discuss patient care. This supported the provision of safe and co-ordinated care.

Activity coordinators we spoke with told us they felt part of the team and doctors appreciated the feedback they offered on patient’s emotional wellbeing.

Twyford ward worked closely with a community charity that visited the ward every week to signpost patients towards services and support. They could organise financial support and grants for patients where needed.

A patient we spoke with on McGill unit was pleased they were referred to a dietitian in a timely way.

Nursing staff worked with local mental health teams, social care and care at home support agencies where appropriate. Information was shared when necessary, although this was sometimes difficult due to differences in record keeping between different providers.

Seven-day services

Trust wide

The trust collected performance data against clinical standards for seven-day working but did not have a strategy for implementing the standards.
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. NHS England publishes the results. The trust told us they had taken part in all the surveys in the past two years. The trust performance was below the national average for clinical priority two and clinical priority eight during weekdays. The trust was meeting the standard for clinical standard five and six and clinical priority eight at weekends.

Priority clinical standard two requires trusts to ensure all patients admitted as an emergency to be assessed by a consultant within 14 hours of arrival at the hospital. The most recently published results at the time of inspection, from the March 2017 survey, showed 65% of patients had a consultant review within 14 hours Monday to Friday but this dropped to 59% at weekends. This was below the national average of 73% Monday to Friday and 70% at weekends. The trust reported that they had worked to improve this standard and that the September 2017 results were 95% overall for weekdays and weekends.

Priority clinical standard five requires trusts to ensure all inpatients 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 the timescales for diagnostic tests. The March 2017 survey results showed 100% performance against the target Monday to Friday and at weekends.

Priority clinical standard six requires trusts to ensure inpatients have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant speciality guidelines, either on-site or through agreed networked arrangements with clear written protocols. The March 2017 showed the trust achieved 100% performance against the target for weekdays and weekends.

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 patients were to be seen and reviewed by a consultant at least once every 24-hours. The March 2017 survey results showed performance was 87% Monday to Friday and dropped to 70% at weekends. This was below the national average performance of 91% for weekdays the same as the national average of 70% at weekends.

Health promotion

Andover War Memorial Hospital

People who use services were empowered and supported to manage their own health, care and wellbeing to maximise their independence.

On Kingfisher ward we saw that an activity coordinator had arranged a programme of activities for patients on the ward including bingo, movie mornings, hand and nail care. The activities were designed to encourage social interaction and engagement. Patients we spoke with were positive about the activity programme which included visits from a ‘pets as therapy’ dog.

Kingfisher ward were part of the trust wide ‘end pyjama paralysis’ campaign where staff encouraged patients to get dressed and out of bed whenever possible. The campaign aimed to help patients feel less ‘hospitalised’ and support them to maintain their independence in preparation for returning home.
Basingstoke and North Hampshire Hospital

People who use services were empowered and supported to manage their own health, care and wellbeing to maximise their independence.

We saw a range of health promotion leaflets were available on medical wards and departments. The leaflets were available in English but staff could access translation and interpreting services for patients for whom English was not their first language.

Medical wards were part of the trust wide ‘end pyjama paralysis’ campaign where staff encouraged patients to get dressed and out of bed whenever possible. The campaign aimed to help patients feel less ‘hospitalised’ and support them to maintain their independence in preparation for returning home.

Royal Hampshire County Hospital

People who use services were empowered and supported to manage their own health, care and wellbeing to maximise their independence.

We saw a range of health promotion leaflets were available on medical wards and departments. The leaflets were available in English but staff could access translation and interpreting services for patients for whom English was not their first language.

We observed an activity session on Wykeham ward where patients were doing a puzzle and having a cup of tea.

Medical wards were part of the trust wide ‘end pyjama paralysis’ campaign where staff encouraged patients to get dressed and out of bed whenever possible. The campaign aimed to help patients feel less ‘hospitalised’ and support them to maintain their independence in preparation for returning home. We saw that positive patient feedback was displayed outside Freshfield ward that showed how much patients appreciated being supported to wear their own clothes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Trust wide

The trust reported that from April 2017 to February 2018 Mental Capacity Act (MCA) training had been completed by 71.3% of staff within medicine. No trust target was set for this course, however, medical/dental staff had a completion rate of 68.5% and nursing staff had a 71.8% completion rate.

The trust reported that the Deprivation of Liberty training was part of MCA training modules and was not a separate course. MCA training is not mandatory, although the current training completion rate is 69% trust wide.

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

The trust had an up to date Mental Capacity Act policy, last reviewed in December 2015 and due for review in December 2018. The policy included information for staff on using the deprivation of liberty safeguards including a protocol and process flowchart for staff to follow.
The trust had put a risk relating to difficulties gaining standard authorisations for deprivation of liberty safeguards on the medical division risk register. The trust had a process in place to ensure high risk patients were prioritised and assessed by best interest assessors to mitigate this risk and the risk register showed that this risk was reviewed in January 2018.

**Andover War Memorial Hospital**

**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.**

Staff we spoke with confirmed they had received training in the mental capacity act and could describe how they used the principles in their work.

We reviewed two Deprivation of Liberty Safeguard (DoLs) applications completed for patients on Kingfisher ward at Andover War Memorial Hospital. We saw that for both applications mental capacity assessments were completed at the time of application. We saw in a patient record that staff had held a best interest meeting for the patient. Staff told us the safeguarding team keep track of DoLs applications and follow them up with the local authority.

In endoscopy written consent was taken from patients before the procedure. Nurse endoscopists received training in consent and had a competency signed off by a doctor.

The trust did not carry out consent audits in endoscopy. The trust responded that they had not carried out any consent audits in endoscopy or cardiology in the past year. The trust reported no consent audits were completed as staff from JAG (a quality improvement and service accreditation programme for gastrointestinal endoscopy) had visited and raised no concerns about the consent process in endoscopy.

**Basingstoke and North Hampshire Hospital**

**Staff understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 was variable. Staff did not always effectively support patients who lacked the capacity to make decisions about their care.**

Staff we spoke with confirmed they had received training in the mental capacity act and could describe how they used the principles in their work. However, staff we spoke with felt training was limited and did not provide them with the appropriate skills to care for patients with mental health needs and learning disabilities. Staff said the training provided an overview of the legislation but they would benefit from learning skills and techniques to better care for patients with a mental health or learning disability.

Staff understanding of the relevant consent and decision-making requirement of legislation and guidance, including the Mental Capacity Act 2005 was inconsistent and documentation was poor. Deprivation of Liberty Safeguards paperwork was missing for a patient on F2 ward. Staff explained that when they make an application they do not store a copy of the paperwork until authorisation is granted. On F2/F3 we found one Deprivation of Liberty Safeguards application form in a patient’s notes and staff could print off a copy of the completed application for a second patient.

Documentation of mental capacity assessments was poor. Of the ten care records we reviewed, two included a detailed mental capacity assessment that explained the decision-making process. Patients’ notes referred to treating patients in their best interests but we were unable to find any documented best interest decisions or processes to ensure that people were not deprived of their
liberty illegally. We saw patients being restricted with bed rails without the patients’ consenting or a documented capacity assessment.

Nursing staff lacked awareness of their responsibilities under the Mental Capacity Act, with several nursing staff telling us it is the doctors’ responsibility to complete mental capacity assessments. Nurses we spoke with lacked confidence to complete mental capacity assessments and paperwork. Nurses relied on medical staff to complete forms and make decisions about consent and capacity.

We reviewed four patient records in relation to do not attempt cardiopulmonary resuscitate orders (DNACPR) on E3 ward. We found one of the four was completed correctly. Two of the four patients’ records stated the patient lacked capacity but there was no record of a mental capacity assessment in the patients notes. Of the four records reviewed one was a community DNACPR dated April 2015. The name of the consultant was illegible and the DNACPR had not been reviewed. This meant the hospital could not be assured that the DNACPR form was valid.

At the multidisciplinary meeting we observed on the acute assessment unit we saw that consent and capacity issues were discussed issues were raised and plans agreed.

The trust did not carry out consent audits in endoscopy. We requested evidence of consent audits in endoscopy and cardiology. The trust responded that they had not carried out any consent audits in endoscopy or cardiology in the past year. The trust reported no consent audits were completed as staff from JAG (a quality improvement and service accreditation programme for gastrointestinal endoscopy) had visited and raised no concerns about the consent process in endoscopy.

Royal Hampshire County Hospital

Staff understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 was variable. Staff did not always effectively support patients who lacked the capacity to make decisions about their care.

Understanding of the relevant consent and decision-making requirement of legislation and guidance, including the Mental Capacity Act 2005 was inconsistent and documentation was poor.

On Freshfield ward we reviewed Deprivation of Liberty Safeguards (DoLS) documentation for four patients. In all four of the records reviewed there was no evidence staff had completed a mental capacity assessment to evidence the patient was unable to consent to stay at the hospital. There was no record in patient notes to explain how care would be provided in the best interest of the patient if they lacked capacity. There was no evidence in patient notes regarding discussion with the patient and relatives or carers, this was not in line with the trust DoLs policy. We found that two out of four patients DoLS applications we reviewed had expired, this meant the hospital could not be assured it was lawfully depriving patients of their liberty.

Staff we spoke with on Freshfield ward were not aware of trust a process to monitor DoLS authorisations. We raised this with the deputy ward sister and they told us that the applications were renewed automatically, this was not the trust policy.

The DoLs policy included a screening checklist and a pathway checklist to support staff in making appropriate DoLs applications. However, we did not see this screening checklist in use in any of the records we reviewed.

In endoscopy written consent was taken from patients before the procedure. Nurse endoscopists received training in consent and had a competency signed off by a doctor.
The trust did not carry out consent audits in endoscopy. We requested evidence of consent audits in endoscopy and cardiology. The trust responded that they had not carried out any consent audits in endoscopy or cardiology in the past year. The trust reported no consent audits were completed as staff from JAG (a quality improvement and service accreditation programme for gastrointestinal endoscopy) had visited and raised no concerns about the consent process in endoscopy.

Is the service caring?

Compassionate care

Trust wide

Trust wide Friends and Family test performance
From March 2017 to February 2018, the friends and family test response rate for medicine at the trust was 38% which was better than the England average of 25%

Andover War Memorial Hospital

Staff cared for patients with compassion and kindness. Feedback from patients was consistently positive about the way staff treated them.
Patients on Kingfisher ward were positive about staff and told us staff were ‘helpful and kind.’ Patients appreciated staff took the time to have a chat when possible.
Patients we spoke with confirmed they were treated with dignity and respect. For example, a patient told us how they had been made to feel comfortable whilst having a bath. However, on the endoscopy service we were not assured staff understood their responsibilities to provide care in single sex environments to protect the privacy and dignity of patients as the service ran mixed sex lists and a mixed sex ENT clinic was running at the same time as the endoscopy service. There was no arrangement for single-sex lists.
The results of the Friends and Family test were displayed on Kingfisher ward. In April 2018 there were 17 responses and 94% of patients would recommend the service.
The patient-led assessment of the care environment (PLACE) in the interim 2018 report scored Andover War memorial hospital 85% for privacy, dignity and wellbeing.

Basingstoke and North Hampshire Hospital

Patients were sometimes not treated with kindness and respect when receiving treatment. Some people using the service had concerns about the way staff treated them. Some staff did not see privacy and dignity as a priority.
Feedback from patients about staff attitudes and behaviours was mixed. Patients we spoke with raised the following concerns –

- On the acute assessment unit, we spoke with a patient who did not feel safe at night. They told us, ‘I would hate it if a family member was here.’ The patient had witnessed that an elderly patient in the bed next to her was left for long periods without support when they needed help sitting up. We observed the patients in this bay for 15 minutes and saw there was no staff interaction with patients and that patient said they were ‘very bored.’

- On E4 ward a relative told us that a nurse had been rude and aggressive towards them when they asked for a hot evening meal to be arranged for a patient. The patient was not offered pain relief and when their relative went to ask a nurse for some they overheard the nurse being disrespectful and calling the patient a ‘moaner.’ The patient felt nursing staff had been unprofessional and unfriendly. The patient was also upset a doctor gave their
diagnosis in an open ward area where other patients could overhear. We raised concerns about the behaviour of this nurse at the time of inspection.

Response to call bells was not always prompt. On Overton unit a patient we spoke with told us call bells were not answered quickly and they felt ‘lucky’ to have a stoma and catheter as they did not need support to go to the toilet like other patients on the unit. Another patient told us staff took up to half an hour to answer call bells. A member of staff we spoke with confirmed that due to staffing levels call bells took a long time to answer. We saw an incident had been reported by a staff member on Overton in March 2018 where a patient had used their mobile phone to call the nursing station to get staff attention after multiple call bells in the bay had been ringing for about 10-15 minutes with no answer. A member of staff at the desk requested the help of therapy staff to help out as there was very low staffing levels.

Staff did not always maintain the privacy and dignity of patients. On the acute assessment unit, we observed a lady sitting out in a chair only wearing in a night dress with her bottom half exposed. Staff did not support her to cover up.

We were not assured staff understood their responsibilities to provide care in single sex environments. On the acute assessment unit, we saw male and female patients next to each other in trolley bay. This was not in line with Department of Health guidance on mixed sex accommodation.

On the coronary care unit there was CCTV cameras that monitored two side rooms staff told us that patients were told about this. However, we were not assured the trust had a process in place to ensure informed consent was obtained and details of consistency in the way that this was managed.

We saw that whiteboards displaying patients’ information were displayed in open ward areas on Freshfield and Shawford wards. This did not protect patient privacy and confidentiality.

However, most patients we spoke with were positive about the care they had received. For example –
- On the acute assessment unit, a patient told us ‘staff have been brilliant, nothing is too much trouble and they are always smiling and cheerful.’
- A patient on F1 ward told us ‘I can’t fault the hospital.’
- A patient on F2 ward told us staff always call her by her preferred nickname
- Patients in the stroke ward told us that the staff had been ‘brilliant’.

We also witnessed staff treating patients with kindness and compassion. For example –
- The clinical matron on F2 and F3 wards was very attentive to patient needs whilst we were speaking with them on the ward during the inspection. They put patient care first and clearly knew their patients well.
- On the cardiology ward we saw that a patient was seemingly walking for the first time and it appeared to have been a long time since they were able to. Three members of staff all offering encouraging and positive reinforcement, obviously very excited for the gentleman and stating they were very proud of him.

The service displayed positive feedback from patients on the wards. For example, we saw thank you cards on F2 and F3 wards and positive patient feedback displayed at the Candover clinic. At the Candover Clinic we saw that the most recent Picker survey showed 100% of staff on this unit would recommend the unit to friends and family and as a place to work. The results of the Friends and Family test were displayed on the acute assessment unit. For May 2018 there were 68 responses (40% response rate) and 88% of patients would recommend the service.
The patient-led assessment of the care environment (PLACE) in the interim 2018 report scored Basingstoke and North Hampshire Hospital 79.70% for privacy, dignity and wellbeing.

Friends and Family test performance at Basingstoke and North Hampshire Hospital

From March 2017 to February 2018, Basingstoke and North Hampshire Hospital had a response rate of 35% (based on 3,077 responses).

A breakdown of the friends and family test performance by ward for medical wards at Basingstoke and North Hampshire Hospital with total responses over 100 is below. The monthly figures show recommendation percentage and not response rates.

Friends and family Test – Response and recommendation rates from March 2017 to February 2018, by ward

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Highest score to Lowest score

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

Ward BAEC had the lowest response rate with 27%, whilst ward EIW had the highest response rate with 86%.

Royal Hampshire County Hospital

Staff cared for patients with compassion and kindness. Feedback from patients was consistently positive about the way staff treated them.

Feedback from patients about staff was consistently positive. For example—

- A patient on Victoria ward told us staff are ‘superb, caring, knowledgeable, wonderful’
- A patient on Twyford ward said, ‘staff introduce themselves and are friendly’
- A patient on Twyford ward said, ‘I would be happy if a family member were to stay on this ward, I’ve had a pleasant stay.’

Patients we spoke with on Victoria ward said staff responded to call bells in a timely manner. Staff took time to interact with patients whenever possible. For example, a patient we spoke with on Freshfield ward told us the clinical matron had painted her nails in the morning. On Freshfield ward we saw good interaction between patients, the activity coordinator and a volunteer watching a nature programme on the television together.

On Victoria ward we observed the vascular team reviewing patients. We saw that they maintained patient’s privacy and dignity, drawing curtains around patients before each consultation.

Staff put the needs of the patients first. For example, the clinical matron on Twyford ward told us if patients want to give something to staff as a thank you, staff always ask for bubble bath for use by other patients.
The patient-led assessment of the care environment (PLACE) in the 2018 interim report score Royal Hampshire County Hospital 72 % for privacy, dignity and wellbeing.

We observed good interaction with patients and their family on the stroke ward. Staff spent time supporting patients and care was not rushed and staff were very sensitive to patients’ emotional needs.

**Friends and Family test performance at the Royal Hampshire County Hospital**

From March 2017 to February 2018, Royal Hampshire County Hospital’s response rate was 39% (based on 2,275 responses).

A breakdown of the friends and family test performance by ward for medical wards at Royal Hampshire County Hospital with total responses over 100 is below. The monthly figures show recommendation percentage and not response rates.

**Friends and family Test – Response and recommendation rates from March 2017 to February 2018, by ward**

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Highest score to Lowest score

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Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

McGill acute medical unit had the lowest response rate with 33%, whilst Clifton ward (acute elderly care) had the highest response rate with 66%.

*(Source: NHS England Friends and Family Test)*

**Emotional support**

**Andover War Memorial Hospital**

Staff provided emotional support to patients to minimise their anxiety or distress.

We observed staff supporting patients and responding to their needs in and communicating in appropriate way.

A patient whose family were unable to visit told us ‘the staff are marvellous – so supportive.’

Another patient told us the physiotherapists had been ‘very encouraging.’

Staff told us dementia volunteers visited the ward on a regular basis to support patients.

**Basingstoke and North Hampshire Hospital**

We observed staff supporting patients and responding to their needs in and communicating in appropriate way.

Staff had access to the dementia team who could provide one to one support to patients living with dementia. We saw a member of the dementia team offering emotional support and
distraction to patients across F1 and F2 wards. Staff were positive about the support the dementia team provided.

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 verbal de-escalation skills.

Patients were positive about the support from activity co-ordinators. We observed an activity coordinator with a patient in the ‘sunflower suite’ on F2. They were doing a reminiscence exercise together and interacting well.

The chaplaincy team offered pastoral support to patients and staff at the hospital of all faiths and none. Staff could access chaplaincy support for patients through the hospital switchboard. The chaplaincy team delivered services on a Sunday to patients at the bedside, on request.

**Royal Hampshire County Hospital**

The emotional needs of patients and families were not always considered and responded to appropriately.

On the McGill acute medical unit, we observed that a patient’s family was given the news their relative was at end of life in an open ward area. Staff did not attempt to provide privacy or close the curtains around them. The trust told us this was the family’s choice. However, the family were visibly upset and staff did not take action to comfort them. We observed staff not offering the family support for ten minutes. We raised this with the ward sister at the time. The sister then approached the family once we had raised this with them.

Staff had access to the dementia team who could provide one to one support to patients living with dementia. Staff were positive about the support the dementia team provided.

The chaplaincy team offered pastoral support to patients and staff at the hospital of all faiths and none. Staff could access chaplaincy support for patients through the hospital switchboard. The chaplaincy team delivered services on a Sunday to patients at the bedside, on request. Activity coordinators organised a weekly coffee morning for patients in the chapel. A ‘pets as therapy’ dog attended Freshfield ward every week.

Staff on Twyford ward had access to a clinical psychologist every month. Staff could choose whether information was fed back to the clinical matron from the clinical psychologist about staff wellbeing. We saw that staff on Shawford ward had access to a quiet room for breaking bad news to patients and families.

The endoscopy service had access to private rooms for breaking bad news. Staff were able to describe clearly the process for informing patients of test results and would involve the clinical nurse specialist and consultant in sharing test results with patients.

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

**Trust wide**

The trust supported ‘John’s campaign.’ The campaign aims for carers to have the right to continue caring for the loved throughout their hospital stay, should they wish to do so.

**Andover War Memorial Hospital**
Staff involved patients and those close to them in decisions about their care and treatment.

Patients we spoke with on Kingfisher ward understood their plans for rehabilitation and discharge home. For example, a patient we spoke with understood the exercises the physiotherapist had given them and were aware staff had visited their home to arrange a lower bed and a raised toilet seat.

Patients felt they had enough information about their care. One patient we spoke with was very positive about the handbook the physiotherapist had given them.

Basingstoke and North Hampshire Hospital
Staff involved patients and those close to them in decisions about their care and treatment.

Staff involved patients in their care to ensure they understood their treatment. For example, patients we spoke with on Overton unit were aware of their rehabilitation goals. Patients we spoke with on the acute assessment unit were positive about how doctors involved them in their treatment. For example, a patient told us ‘the consultant has been good and explained a lot.’ A diabetic patient we spoke with on the acute assessment unit had been allowed to administer their own blood monitoring needle as they were needle phobic and had arranged a referral to the dietician at the patients request.

The dementia team ran a dementia carer’s café once a month at Basingstoke and North Hampshire Hospital, in partnership with local mental health and carers organisations. The café provided a space where dementia carers could access advice and support.

Staff involved family and carers in care and discharge planning as necessary. We observed sensitive discussion of the needs of patients and carers at the morning multidisciplinary meeting on F1 ward.

Staff had access to communication aids to help patients become partners in their care. Staff had pictorial information boards available on the wards and could access the specialist teams for more specialist communication aids.

Royal Hampshire County Hospital
Staff involved patients and those close to them in decisions about their care and treatment.

The dementia team ran a dementia carer’s café once a month at Royal Hampshire Hospital, in partnership with local mental health and carers organisations. The café provided a space where dementia carers could access advice and support.

On Twyford ward, the acute stroke unit, a stroke charity visited the ward on a weekly basis to signpost patients and carers to support available after discharge. The community stroke association supported patients who were ready for discharge. This was a valued service which provided patients with information on benefits and put them in touch with local support group.

Staff had access to communication aids to help patients become partners in their care. Staff had pictorial information boards available on the wards and could access the specialist teams for more specialist communication aids.
Service delivery to meet the needs of local people

Trust wide

Average length of stay

Trust Level average length of stay data

From January 2017 to December 2017 the average length of stay for medical elective patients at the trust was 4.1 days, which is lower than the England average of 5.8 days. For medical non-elective patients, the average length of stay was 8.6 days, which is higher than the England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is similar to the England average.
- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in neurology is lower than the England average.

Elective Average Length of Stay – Trust Level

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 is higher than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)
The trust planned for increases in levels of demand for medical services. We requested the winter management plan for medical services and the trust responded with a document detailing their plans to manage demand during the 2018/2019 winter period. The plan included extending the opening hours of the ambulatory care unit to seven days a week. We also reviewed the trust winter management plan for 2017/2018 winter period and saw the trust had worked with local partners to manage demand and improve patient flow.

Senior leaders were involved in future planning with regional groups and Public Health England to look at changing population needs.

The trust did not report any mixed sex breaches for the medical care service. We requested the trust’s standard operating procedure for management of mixed sex breaches in high acuity areas such as acute assessment units and the hyper acute stroke unit. The trust responded that they did not have a standard operating procedure. We were not assured the trust was monitoring mixed sex breaches and prioritising the privacy and dignity of patients.

Andover War Memorial Hospital

There was no evidence of service planning and the service was using less than 50% of its theatre capacity for endoscopy procedures at the time of the inspection.

Andover War Memorial Hospital average length of stay data

From January 2017 to December 2017 the average length of stay for medical elective patients at Andover War Memorial Hospital was 1.2 days, which was lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 61.7 days, which is higher than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is lower than the England average.
- Average length of stay for elective patients in medical oncology is lower than the England average.

Elective Average Length of Stay – Andover War Memorial Hospital

![Average Length of Stay Chart]

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 rehabilitation service is higher than the England average.
- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in cardiology is higher than the England average.
Non-Elective Average Length of Stay Andover War Memorial Hospital

Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

There was one medical ward and an endoscopy service at Andover Memorial Hospital. Kingfisher ward provided rehabilitation for elderly patients.

We saw that the facilities and premises on Kingfisher ward were appropriate for the services delivered. Relatives we spoke with were positive about the day room on Kingfisher ward which had facilities for visitors to make a hot drink. However, the facilities in the endoscopy service was not appropriate as mixed sex breaches were not managed effectively.

The service used a sunflower symbol to enable them to quickly identify patients living with dementia or a memory problem. We saw sunflower symbols were displayed by patient beds.

The trust had a learning disability nursing team which provided support to staff and patients.

At Andover War Memorial hospital there was no evidence of service planning to make effective use of the endoscopy services. There was no evidence of service planning and the service was using less than 50% of its theatre capacity at the time of the inspection.

Basingstoke and North Hampshire Hospital

The trust planned services in a way that met the needs of local people. However, the environment of the acute assessment unit did not support the provision of single sex accommodation.

Basingstoke and North Hampshire Hospital average length of stay data

From January 2017 to December 2017 the average length of stay for medical elective patients at Basingstoke and North Hampshire Hospital was 3.9 days, which is lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 7.8 days, which is higher than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is similar to the England average.
- Average length of stay for elective patients in neurology is lower than the England average.
- Average length of stay for elective patients in clinical haematology is lower than the England average.

Elective Average Length of Stay – Basingstoke and North Hampshire Hospital
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in cardiology is similar to the England average.
- Average length of stay for non-elective patients in respiratory medicine is lower than the England average.

**Non-Elective Average Length of Stay – Basingstoke and North Hampshire Hospital**

(Source: Hospital Episode Statistics)

The acute assessment unit (AAU) was open 24 hours a day, seven days a week. The unit alleviated pressures from the emergency department.

The trust had recently opened an ambulatory care unit at Basingstoke and North Hampshire Hospital. The unit was located next to the emergency department. Patients were assessed by a nurse and a medical doctor, and appropriate treatment arranged with the aim of safely discharging the patient home. The ambulatory care unit could admit patients to the acute assessment unit or a medical ward if necessary. The ambulatory care unit was open Monday to Friday 9am to 5pm.

The service had a delayed transfer of care ward, Overton unit. The service used this ward for patients who were medically fit for discharge but were unable to be discharged from hospital due to complex circumstances or waiting for packages of care. This released beds on older people’s wards for patients who were clinically unwell. Overton unit was a 25-bed unit but only 16 beds were open at the time of inspection due to low staffing levels.

The trust had set up a clinic for privately funded patients on the grounds of the Basingstoke Hospital site. Candover clinic provided medical care to privately-funded patients. The profits from the private clinic went back into the NHS trust. The clinic had a spacious open area for patients and visitors to socialise which included access to refreshments.
We saw that the facilities and premises were appropriate for the services delivered. Older people’s wards had day rooms so patients and visitors had access to a relaxed environment to socialise in. Patients on wards F2 and F3 had access to the ‘sunflower suite’ a day room with a television and memory box for reminiscence activities for patients living with dementia.

However, the acute assessment unit (AAU) was not being used appropriately to ensure male and female patients were in separate accommodation with separate toilet facilities. A review of the NHS England mixed sex accommodation data showed the trust did not report any mix sex breaches. We were not assured that the trust was reporting mixed sex breaches when they occurred. Staff in the acute assessment unit did not demonstrate that to protect patient’s privacy and dignity, patients must be nursed in single sex accommodation. This meant patients should be accommodated in single sex bays and have access to toilet and bathing facilities without passing through opposite sex accommodation.

The trust supported ‘John’s Campaign’ to allow dementia carers the right to stay with patients living with dementia. Staff on F1 ward had access to recliner chairs so patients could have a family member or carer stay with them next to the bedside.

The service used a sunflower symbol to enable them to quickly identify patients living with dementia or a memory problem. We saw sunflower symbols were displayed by patient beds.

The trust had a learning disability nursing team which provided support to staff and patients.

Royal Hampshire County Hospital

The trust planned and provided services in a way that met the needs of local people.

Royal Hampshire County Hospital average length of stay

From January 2017 to December 2017 the average length of stay for medical elective patients at Royal Hampshire County Hospital was 6.9 days, which is higher than England average of 5.8 days. For medical non-elective patients, the average length of stay was 9.4 days, which is higher than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in medical oncology is higher than the England average.
- Average length of stay for elective patients in clinical haematology is lower than the England average.
- Average length of stay for elective patients in respiratory medicine is similar to the England average.

Elective Average Length of Stay – Royal Hampshire County Hospital

![Average length of stay chart]

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 is higher than the England average.
Average length of stay for non-elective patients in stroke medicine is similar to the England average.
Average length of stay for non-elective patients in geriatric medicine is higher than the England average.

Non-Elective Average Length of Stay – Royal Hampshire County Hospital

![Bar chart showing average length of stay for non-elective patients in different specialties.](image)

*Note: Top three specialties for specific trust based on count of activity.*

(Source: Hospital Episode Statistics)

The McGill acute medical unit was a 46-bed unit and was open 24 hours a day, seven days a week. Staff told us the unit was always busy and had relieved pressures from the emergency department.

The service had a delayed transfer of care ward, Freshfield ward. The service used this ward for patients who were medically fit for discharge but were unable to be discharged from hospital due to complex circumstances or waiting for packages of care. This released beds on older people’s wards for patients who were clinically unwell.

Twyford ward provided hyper-acute stroke care and stroke rehabilitation. The stroke service also had an early supported discharge team. The team enabled patients to return home at an earlier point in their recovery to continue rehabilitating with the support of the hospital stroke therapy team.

Patients were admitted to the medical wards by direct referral from their general practitioner, a ‘step down’ transfer from a critical care unit or through the accident and emergency department.

We saw that the facilities and premises were appropriate for the services delivered. Older people’s wards had day rooms so patients and visitors had access to a relaxed environment to socialise in. During the inspection Wykeham ward was in the process of converting the gym into a large day room for patients to be shared with the ward next door. We saw this room was already being used by an activity co-ordinator for an activity session with patients.

Freshfield ward was a dementia-friendly environment for patients. The ward had a long table where patients and staff could sit. This encouraged interaction between patients and staff and made it easier for staff to observe patients. Freshfield ward had a ‘memory tree’ where patients could add their memories.

The trust supported ‘John’s Campaign’ to allow dementia carers the right to stay with patients living with dementia.
The service used a sunflower symbol to enable them to quickly identify patients living with dementia or a memory problem. We saw sunflower symbols were displayed by patient beds.

The trust had a learning disability nursing team which provided support to staff and patients.

**Meeting people’s individual needs**

**Trust wide**

Dementia tier one training was part of mandatory for all staff. Compliance with dementia training was low, from April 2017 to February 2018 12.7% of medical staff and 63% for nursing staff had completed the training.

The frailty and dementia team based in the emergency department used the comprehensive geriatric assessment (CGA) tool to assess patients. Although based in emergency department the team supported staff on the wards in the management of dementia patients include 1:1 support for patients. The team worked to avoid admissions for patients living with dementia by ensuring patients have the right support and could be discharged home instead of being admitted.

The trust employed discharge coordinators to support discharge processed for patients with complex health and social care needs. They liaised with social care providers, care homes and reablement teams to affect timely and effective discharges. We saw appropriate discharge arrangements were in place people with complex health and social care needs. A team of social workers were based at the hospital to support discharge planning for people with complex health and social care needs. Staff spoke positively about the impact this had on patient treatment and flow.

The trust employed a member of staff to work two days across the three hospital sites to support service defence personnel and their families, particularly with discharge issues.

**Andover War Memorial Hospital**

**On Kingfisher ward staff were aware of meeting patient’s individual needs, including for patient’s living with dementia.**

Nursing staff were aware of ‘This is Me’ booklets for patients living with dementia. Staff asked relatives for these documents if applicable. The ‘This is Me booklet’ is a form provided by the Alzheimer’s society to help healthcare providers in supporting individuals with a cognitive impairment. It can be completed by the patient or someone who knows them. It details the patient’s routine, likes, dislikes, and support or help needed. We saw the ‘This is Me’ document was completed in two of the four patient records we reviewed on Kingfisher ward.

Staff had access to a telephone interpreting service to support callers for whom English was not their first language.

The patient-led assessment of the care environment (PLACE) in the interim 2018 report scored the Andover War Memorial Hospital scored 74.32% for dementia.

**Basingstoke and North Hampshire Hospital**

**The service took account of patients’ individual needs. However, recording of personalised care planning and dementia care plans were poor.**
The hospital took part in the National Audit of Dementia Care in General Hospitals 2016 – 2017 carried out by the Royal College of Psychiatrists and published in July 2017. The trust ranked below the national average for nutrition, assessment, carer communication and carer rating of patient care. Service leads we spoke with told us improving the dementia team and the provision of activity coordinators were part of their plan to improve dementia care across the trust.

The service had a specialist dementia team led by the frailty and dementia matron. The team included a dementia specialist nurse and dementia practitioners. Staff referred patients living with dementia to the team for extra support. The dementia team were available 7am to 7pm, seven days a week. We saw on F1 and F2 wards the team were used to provide one to one care for patients living with dementia.

Nursing staff were aware of hospital passports for patients with a learning disability and ‘This is Me’ booklets for patients living with dementia. The ‘This is Me booklet’ is a form provided by the Alzheimer’s society to help healthcare providers in supporting individuals with a cognitive impairment. It can be completed by the patient or someone who knows them. It details the patient’s routine, likes, dislikes, and support or help needed. Staff asked relatives for these documents where relevant. Of the ten patient care records we reviewed, eight had a diagnosis of dementia or cognitive impairment and six of these had a completed ‘this is me’ booklet. On the acute assessment unit, we found a copy of a hospital passport for a patient with a learning disability in their notes, staff told staff they used this to support the patient.

The trust had adapted wards to create dementia-friendly environments. On F2 and F3 wards we saw clocks were displayed and the day of the week to orient patients living with dementia to time. The name of the nurse in charge of the bay was also shown.

Support for patients in need of extra support was inconsistent. During our inspection a patient living with dementia on the acute assessment unit was supported by an agency mental health nurse. However, staff on other wards told us if patients needed extra support or one to one nursing this had to be provided from the normal nursing numbers and additional staff were not available. A number of staff we spoke with reported relying on carers and families for advice and information on how best to care for patients with a mental health or learning disability diagnosis. Not all staff were aware if there was a learning disability link nurse or champion to support them.

The trust relied on the psychiatric liaison teams and the Approved Mental Health Professionals assessment service out of hours for urgent and emergency mental health needs. Staff we spoke with in AAU told us they had access to psychiatric support 9am to 5pm, out of hours patients go through the emergency department.

The trust had a service level agreement with the local mental health trust to provide psychiatric liaison services for all patients over the age of 18. The adult mental health liaison team provided a liaison service to patients aged 18 to 65, 24 hours a day, 7 days a week. The team offer assessment and guidance to staff about care and treatment for patients with a mental illness. The older person’s mental health liaison team provide support and guidance for patients with a dementia diagnosis over the age of 65 across all wards in the hospital. They ran an on-call system at night. Ward staff felt the psychiatric liaison teams were responsive, supportive and valuable.

Activity coordinators we spoke with were trained in supporting visually impaired patients.

Staff had access to a telephone interpreting service to support callers for whom English was not their first language. On the Cardiology ward we saw staff used a list of phrases to communicate with a patient who did not speak English. We saw the telephone number of the interpreting service was recorded in the patients notes.
The patient-led assessment of the care environment (PLACE) in the interim 2018 report scored the Basingstoke and North Hampshire scored 58.02% for dementia.

Royal Hampshire County Hospital

The service took account of patients’ individual needs. However, recording of personalised care planning and dementia care plans were poor.

The hospital took part in the National Audit of Dementia Care in General Hospitals 2016 – 2017 carried out by the Royal College of Psychiatrists and published in July 2017. The trust ranked below average the national average for nutrition, assessment, carer communication and carer rating of patient care. Service leads we spoke with told us improving the dementia team and the provision of activity coordinators were part of their plan to improve dementia care across the trust.

The service had a specialist dementia team led by the frailty and dementia matron. The team included a dementia specialist nurse and dementia practitioners. Staff referred patients living with dementia to the team for extra support. The dementia team were available 7am to 7pm, seven days a week.

The trust relied on the psychiatric liaison teams and the Approved Mental Health Professionals assessment service out of hours for urgent and emergency mental health needs.

Staff had access to a telephone interpreting service to support callers for whom English was not their first language.

The patient-led assessment of the care environment (PLACE) in the interim 2018 report scored the Royal Hampshire County Hospital scored 55.94% for dementia.

Access and flow

Trust wide access and flow

Trust wide referral to treatment data (percentage within 18 weeks) – admitted performance

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently better than the England average. In the latest period, February 2018, performance showed 97.7% of this group of patients were treated within 18 weeks versus the England average of 88.1%.

(Source: NHS England)

Trust wide referral to treatment (percentage within 18 weeks) – by specialty

Seven out of eight specialties were above the England average for admitted RTT (percentage
within 18 weeks). The dermatology speciality was below the England average with 55.0% compared to 83.3%.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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<tbody>
<tr>
<td>Geriatric medicine</td>
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</tr>
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<td>91.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>100%</td>
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</tr>
<tr>
<td>Cardiology</td>
<td>86.2%</td>
<td>82.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>55.0%</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Records of the April 2018 performance report to the board of directors showed the overall RTT was 90.4% in March 2018, slightly below the target of 92%.

We requested data on the number of medical outliers per day for the months February to March 2018. A medical outlier is when a patient is not placed in the appropriate area. On average there were 56 outliers per day in February and 63 per day in March 2018. The data provided was for medical, surgery and family divisions and not broken down by hospital site.

The trust monitored delayed transfers of care and data. Data showed the number of bed days lost due to delayed discharges in March 2018 was 1607, with those attributable to social care decreasing by 121 compared to February 2018.

The trust collected monthly data on patients ‘stranded’ in hospital for seven days or longer. Data showed at the end of March 2018 there were 400 patients who had been in hospital seven days or longer across the trust. Delayed patient discharges from elderly care wards was on the medical services risk register. The trust was taking action to reduce the risk through daily, weekly and twice weekly multidisciplinary discussions with medical teams and adult services integrated discharge bureau, allocated social workers on some wards. The trust had a discharge improvement plan and was reviewing the effectiveness of delayed transfer of care wards.

The trust used the NHS Safer Care bundle to improve patient flow through the hospital. This recommends that of patients ready for discharge, 33% should be discharged by midday.

The trust used the ‘Red2Green’ days approach, which was part of the NHS Safe Care bundle. This is a visual management system to help identify wasted time in a patient’s journey. It was 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 them towards discharge. We saw wards we visited used the red to green approach on patient information whiteboards and these were updated during multidisciplinary team meetings.

The trust had a standard operating procedure for use of trolleys and chairs in acute assessment units. The policy was in date and staff were aware of the policy.

Patients could be referred directly into the endoscopy service across all sites through direct access electronic referral from the GP. Patients could choose which site to have their endoscopy procedure.
Andover War Memorial Hospital

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not available.

The service had clear arrangements to admit patients. Patients were admitted to Kingfisher ward by referral from a physiotherapist. The admission criteria were medically stable patients with rehabilitation potential. Physiotherapy staff referred patients from the acute medical wards at Royal County Hospital and Basingstoke and North Hampshire Hospital.

Kingfisher ward was included in discussions about overall bed capacity at the bed meeting we observed at Royal Hampshire County Hospital on 14 June 2018.

Royal Hampshire County Hospital managed the waiting list for endoscopy at Andover War Memorial Hospital. Referral to treatment times were provided as trust-wide data and not site specific information.

Basingstoke and North Hampshire Hospital

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were slightly below the trust target at the time of inspection.

Records of the April 2018 performance report to the board of directors showed the overall RTT at the Basingstoke and North Hampshire Hospital was 89.2% in March 2018, slightly below the target of 92%. Medical specialities that dropped below the target included urology, gastroenterology, neurology and rheumatology.

The service had clear arrangements to admit patients. Patients were admitted to the medical wards via direct referral from their general practitioner, a ‘step down’ transfer from a critical care unit or through the accident and emergency department. Patients were admitted to the coronary care unit through the heart failure clinic. Patients who needed non-invasive ventilation were admitted to the respiratory ward (E3) from the acute assessment unit or critical care.

The Candover clinic provided medical care for privately-funded patients. Patients were admitted to the Candover clinic – for medical care or post-surgical care. All medical specialities were accepted. Candover clinic did not provide treatment to children under 18, patients with tracheostomies or patients needing non-invasive ventilation. These patients would be treated in by the NHS hospital.

Staff we spoke with told us they started planning for patient discharges at an early stage in the patient admission to hospital. However, patient records showed discharge planning documents in nursing records were not completed in most of the records we reviewed. We saw that estimated discharge dates were included on whiteboards used to review patient care. We saw that discharge dates were reviewed regularly at board rounds and multidisciplinary meetings. Most patients we spoke with were aware of their discharge plans.

The trust used the ‘Safer flow’ care bundle and ‘Red to Green days’ to support patient flow and reduce delayed discharges. The trust employed patient flow co-ordinators to support the discharge planning process. We saw that the acute assessment unit had a patient flow co-ordinator who attended all bed meetings and was able to liaise with other patient flow co-ordinators. This role reduced the administrative burden for nursing staff. Clinical matrons could attend the bed meeting whenever necessary and they could view the bed report at any time throughout the shift. The clinical matron also had viewing access to the emergency department data board which helped with preparation for flow.
We observed a ‘stranded patient meeting’ on F1 ward during the inspection. The purpose of this meeting was to review patients who were medically fit for discharge but remained in hospital due to complex discharge arrangements. We saw that the meeting was effective and the discussions resolved issues.

At the time of inspection there were three outliers on coronary care unit, two respiratory and one general medicine. The trust collected trust wide data on the number of outliers per day to monitor patient flow through the hospital.

The service monitored the length of stay on the acute assessment unit. Trust data on the average length of stay at AAU showed between June 2017 and June 2018 the average length of stay was one day, this was in line with expectations.

The trust had taken action to improve patient flow through the hospital. An ambulatory care unit had recently opened at Basingstoke and North Hampshire hospital. The aim of the ambulatory care unit was to avoid patients being admitted to hospital unnecessarily. A patient we spoke with who had a respiratory long-term condition that needed regular management through hospital visits said how much their experience had improved due to the much-improved environment, reduced time it took to access the hospital, promote assessment and management of his needs. The clinical matron told us the service had reduced AAU workload by 27%.

**Royal Hampshire County Hospital**

**Patient’s had timely access to services. Referral to treatment times at Royal Hampshire County Hospital were met at the time of inspection.**

Records of the April 2018 performance report to the board of directors showed the overall RTT at the Royal Hampshire County Hospital was 91.9% in March 2018, close to their target of 92%. The only medical speciality that dropped below the target was neurology.

The McGill acute assessment unit had a clear standard operating procedure for triage, admission and discharge of patients to appropriate wards. The document was dated December 2017 and for review December 2020. The maximum length of stay for patients on the acute assessment unit was 72 hours. However, some patients stayed longer than this due to pressures on the availability of beds in the hospital.

The trust employed patient flow coordinators to support the discharge planning process. Patient flow coordinators attended bed meetings three times a day. Problems with patient discharges were escalated to this meeting. Patient flow coordinators told us the main causes of delayed discharges were transport, pharmacy and social services.

On Wykeham ward staff we spoke with told us there were multiple bed moves after 4pm and overnight on the wards. Bed moves at night can disturb patients, especially those living with dementia and should be avoided where possible.

The hospital had a discharge lounge that opened in February 2018. The discharge lounge was open 8am to 8pm Monday to Friday. The trust was in the process of reviewing the opening hours as they considered 8pm to be quite late for patients to be discharged home. The lounge had room for eight patients but staff told us three or four patients a day used the lounge. Staff had access to clothing for patients who didn’t have their own clothes to travel home in.

Staff we spoke with told us they started planning for patient discharges at an early stage in the patient admission to hospital. However, patient records showed discharge planning documents in nursing records were not completed in most of the records we reviewed. We saw that estimated discharge dates were included on whiteboards used to review patient care. We saw that
Discharge dates were reviewed regularly at board rounds and multidisciplinary meetings. Most patients we spoke with were aware of their discharge plans.

On Shawford ward we saw the patient whiteboard showed details of delayed discharges. At the time of inspection, the board showed there were four stranded patients, including two who had been stranded over a week due to social care or allocation of a social worker. Staff we spoke with told us the main delays to patient discharge were arranging packages of social care. Staff told us pharmacy caused the most common internal delays. There was no allocated pharmacist on Shawford ward.

Patients had timely access to the hyper acute stroke unit, Twyford ward. National best practice guidelines dictated that all suspected stroke patients should be admitted directly to the hyper acute stroke unit, rather than follow the general medical pathway of admission to the acute assessment unit. The trust monitored compliance with the 85% target for direct admissions to the hyper acute stroke unit. Data showed that the trust did not meet the target in March 2018, 70% of patients were admitted directly, the average performance for the period April 2017 to March 2018 was 80%. Breaches with the 85% target were a standard item on the monthly stroke strategy meeting. Reasons for breaches and a summary of the patient pathway were evident from a review of the meeting minutes.

The stroke unit also used a nationally recognised tool for predicted date of discharge which enabled a multi-disciplinary approach in ensuring plans were developed at an early stage and appropriate support could be in place.

The hospital had bed meetings three times a day plus a bed review meeting at five o clock. The bed meeting was led by the director of the day. We observed the bed meeting at Royal Hampshire Hospital on 14 June 2018. The process identified how many empty beds were available in the hospital, how many planned discharges and how many patients had been admitted. The meeting was useful and efficient. Staff used the meeting to manage patients’ flow proactively. Ward flow facilitators discussed coordinating to take out drugs and transport to ensure patient needs were met. Medical outliers were discussed at this meeting. At the time of the inspection there were six stroke patients on Clarke ward. A member of staff from the local ambulance trust attended the bed meeting to review patient transport issues.

We visited Kemp Welch surgical ward to check if there were any medical outliers and found there were no medical outliers on the surgical ward on the afternoon of 5 July 2018. Staff we spoke with told us the ward was used for medical outliers during busy winter periods. Staff said lower acuity medical patients were placed as outliers and they were able to access the relevant consultants to review medical patients when necessary. Staff we spoke with told us the endocrinology team usually covered the medical outliers on surgery wards but the relevant team could be accessed to review medical patients.

Learning from complaints and concerns

Trust wide

Trust wide summary of complaints

From March 2017 to February 2018 there were 110 complaints about medical care. The trust took an average of 32.3 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 25 days.

The most prevalent complaint themes were patient care with 30 (27.3%), admissions and discharges with 21 (18.2%) and communication with 19 complaints (27.3%).

Basingstoke and North Hampshire Hospital had the most complaints about medical care with 66
(60.0%), followed by Royal Hampshire County Hospital with 42 (38.2%) and Andover War Memorial Hospital with two complaints (1.8%).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We reviewed the last three complaints to the service and found they were responded to within 55 working days. The three complaint responses we reviewed included an apology to complainants and an investigation of the complaint. There was evidence of learning identified following the complaints.

The medical division board report included the percentage of complaints responded to in 25 working days. The average figure for January 2017 to January 2018 was 63%. The number of complaints per month and themes were described in the governance summary of the board report. In January 2018, 32 formal complaints were opened. The highest number of complaints related to patient care, followed by clinical treatment and communication.

We saw that complaints were discussed at clinical governance meetings.

Andover War Memorial Hospital

The trust’s responses to complaints were not always completed in a timely manner.

Information leaflets on how to contact the patient advice and liaison service and how to make a complaint were available on the ward. The leaflet was in English and was available in large print and explained help was available for people for whom English was not their first language. An easy read version of the how to make a complaint leaflet was available on the trust website.

Basingstoke and North Hampshire Hospital

The trust’s responses to complaints were not always completed in a timely manner.

Staff were aware of learning from complaints. For example, on the acute assessment unit a staff member had conflict resolution training following a complaint about staff attitude.

We saw the service displayed ‘you said we did’ boards with evidence of action to improve the service. For example, at the Candover clinic jugs of water were provided as patients preferred them to bottled water.

Information leaflets on how to contact the patient advice and liaison service and how to make a complaint were available on the ward. The leaflet was in English but was available in large print and explained help was available for people for whom English was not their first language. An easy read version of the how to make a complaint leaflet was available on the trust website.

Royal Hampshire County Hospital

The trust’s responses to complaints were not always completed in a timely manner.

Staff were aware of learning from complaints. For example, staff were aware of a complaint about delayed to discharge and the importance of clear communication with patients and carers.

We saw the service displayed ‘you said we did’ boards with evidence of action to improve the service.

Information leaflets on how to contact the patient advice and liaison service and how to make a complaint were available on the ward. The leaflet was in English but was available in large print
and explained help was available for people for whom English was not their first language. An easy read version of the how to make a complaint leaflet was available on the trust website.

Is the service well-led?

Leadership

Trust wide leadership

Senior leaders were not always aware of the risks, issues and challenges in the service.

There was one trust-wide medical division management team that worked across the three hospital sites.

The trust divided management of services into three care groups. Medical care including older people’s care wards were managed under the medical services group.

There were clinical directors for speciality medicines, long term conditions, and unscheduled care. The acute assessment units were managed by the clinical director for unscheduled care.

The trust had succession planning strategy and an operational development and leadership strategy 2018 – 2022 to develop the leadership skills of staff. Staff had access to external and in-house leadership training. There was a programme to develop clinical matrons and clinical directors. Part of the strategy was to support healthcare assistants to train and move into nursing roles.

Andover War Memorial Hospital

Senior managers were not aware of what was happening on the frontline at Andover War Memorial hospital and did not prioritise the risks and quality of the service. There were few examples of leaders making a demonstrable impact on the quality or sustainability of services.

Trust and divisional management did not have an awareness of the risks relating to medicines management and resuscitation equipment at Andover War Memorial Hospital.

Trust management and division management did not have an awareness of the risk that patient dignity and privacy was compromised at the hospital as endoscopy lists were mixed sex lists.

Staff we spoke with said members of the executive team had visited the ward.

Kingfisher ward was managed by a clinical matron. Staff felt supported by immediate managers and were positive about the team working.

Basingstoke and North Hampshire Hospital

Managers had the skills and abilities to run a service.

Wards we visited had clinical matrons and ward sisters who managed the ward and worked alongside nursing staff.

Clinical matrons we spoke with confirmed leadership training was available to staff. There was a rolling programme of leadership training to support staff.

Royal Hampshire County Hospital
Managers had the skills and abilities to run a service.
Wards we visited had clinical matrons and ward sisters who managed the ward and worked alongside nursing staff.
On Twyford ward, the clinical matron we spoke with felt empowered by the trust.

Vision and strategy

Trust wide vision and strategy
The trust had a vision for what it wanted to achieve but it was in an early stage of development.
The medical division had a strategy that was agreed in May 2018, the month before the inspection. The strategy had clear priorities for ensuring sustainable high-quality care. The priorities included – outstanding care for patients, empowering staff and innovating for the future.
The medical division strategy included references to Andover War memorial hospital in terms of improving palliative and end of life care and developing the home care team.
Senior staff we spoke with were aware of the trust strategy in relation to the focus on the frailty pathway.
However, there was no service development plan for the endoscopy service at Andover War Memorial Hospital.

Culture

Trust wide culture
Duty of Candour was not included in staff mandatory training but staff were encouraged to carry out an e-learning module on ‘Being Open.’

Andover War Memorial Hospital
Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
We were not assured that managers took action to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority.
Staff we spoke with were positive about the support from occupational health and the trust’s focus on staff wellbeing.

Basingstoke and North Hampshire Hospital
Creating a positive culture was not always given sufficient priority. Managers did not always take action to address staff behaviours that were not in line with the trust values.
We were not assured that managers took action to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. Staff told us that action was taken if staff did not behave in line with the trust’s values if they were senior.
We raised a concern about the behaviour we observed of a nurse. The trust took the matter seriously and commenced an investigation.
The clinical matron on F1 ward had completed a quality improvement project to improve the culture. Staff pledges were displayed at the entrance to the ward. She had implemented open visiting times to improve patient carer involvement and support staff to engage with families more often. Staff we spoke with were positive about improvements to the culture on this ward.
Staff described a ‘no blame’ culture within the trust. Staff we spoke with confirmed they would be confident to raise a concern to their line manager or clinical matron if they needed to.

Staff we spoke with were aware of the trust values and that they were included in the induction programme.

**Royal Hampshire County Hospital**

**Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

We were not assured that managers took action to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. Staff told us that action was taken if staff did not behave in line with the trust’s values if they were senior.

Staff described a ‘no blame’ culture within the trust. Staff we spoke with confirmed they would be confident to raise a concern to their line manager or matron if they needed to.

Staff we spoke with were aware of the trust values and told us they were included in the induction programme.

**Governance**

**Trust wide governance**

The trust had an approach to improving the quality of its services but it was not effective enough. The trust governance process for managing medicines safely and declaring mixed sex breaches were not effective.

The 2015 inspection identified issues relating to medicines management, during this inspection we found further regulatory breaches relating to medicines. This meant we could not be assured the trust had an effective governance process for managing medicines safely.

Clinical matrons were part of the management structure, the clinical matron and operational senior manager presented a one-page score card of what was going well, incidents, risks, clinical quality and performance to the Medical Director and Operations Director every month.

The governance structure included, daily ward safety huddles, monthly ward meetings and monthly medical specialised level clinical governance meetings. Issues from the speciality clinical governance meetings were escalated up to the monthly medical division governance board.

Managers discussed the quality of services at monthly clinical governance meetings. We reviewed clinical governance meetings for cardiology, diabetes, respiratory, stroke and frailty. The minutes showed the meetings had standard agenda items which included: performance, governance, recruitment and service improvements. There was little evidence that incidents were discussed at clinical governance meetings. This meant opportunities to share learning following incidents were missed.

Staff we spoke with at all levels were clear about their roles and understood what they were accountable for.

A medicine division ‘ward scorecard’ was included in the medical division monthly board report. The ward scorecard detailed performance of electronic audit results of NEWS scores, falls assessments, % of harm free care, nutrition assessments and use of the dementia care bundle.

The trust had set up a Patient Safety Group, in April 2018 that reported to the Patient Safety, Effectiveness and Experience Group (PSEEG). The PSEEG meeting reported to the Trust Clinical Quality and Safety Committee (CQSC). The purpose of the meetings was to support continuous
improvement and learning. We reviewed the terms of reference for the Patient Safety Group and saw that the falls, nutrition, dementia and tissue viability leads were included in the membership of the group. The aim was to have a joined-up approach to reducing incidents of patient harm. The June 2018 patient safety group meeting minutes showed the safety thermometer results, tissue viability and one to one supervision for dementia patients were discussed. The patient safety group had recently been set up at the time of the inspection so it was not possible to assess its impact.

We were not assured of the trusts governance processes with regard to mixed sex breaches. The trust had not declared any mixed sex breaches to NHS England in the past year, in line with nationally agreed mixed sex accommodation reporting arrangements. Therefore, the trust was not using the national mixed sex accommodation guidance appropriately.

Andover War Memorial Hospital
The trust had an approach to continually improve the quality of its services but we were not assured of its effectiveness to keep patients safe. There were gaps in some of its governance processes including management of mixed sexed environments.

A clinical matron we spoke with told us they attended a weekly matron meeting and they found this useful for shared learning and support.

Wards and departments had local performance dashboards based on the trust quality governance scorecard these were shared with staff at ward meetings and we saw them displayed in staff areas.

Basingstoke and North Hampshire Hospital
The trust had an approach to continually improve the quality of its services but we were not assured of its effectiveness to keep patients safe. There were gaps in some of its governance processes including management of mixed sexed environments.

We reviewed the ward meeting minutes for E1 for March 2018. The standard agenda included governance, appraisals and training, incidents and complaints.

We reviewed the communication files used to share ward meeting minutes for F1, F2, F3 and saw that monthly meetings did not always go ahead due to staffing pressures.

One clinical matron we spoke with was positive about the ‘ward to board’ meetings with the chief nurse. They told us it was a useful and empowering meeting where staffing, budgets and quality improvement were discussed.

Wards and departments had local performance dashboards based on the trust quality governance scorecard these were shared with staff at ward meetings and we saw them displayed in staff areas.

Royal Hampshire County Hospital
The trust had an approach to continually improve the quality of its services but we were not assured of its effectiveness to keep patients safe. There were gaps in some of its governance processes including management of mixed sexed environments.

Staff we spoke with told us they did not have regular ward meetings. Wykeham ward had daily safety huddles. We reviewed two record sheets for the safety huddles on Wykeham ward and found staffing and risks to service users were discussed.
Wards and departments had local performance dashboards based on the trust quality governance scorecard these were shared with staff at ward meetings and we saw them displayed in staff areas.

Management of risk, issues and performance

Trust wide

Not all the risks identified on inspection were included and it was not clear if risk registers were reviewed regularly.

There was a risk register for the medical division. At the time of the inspection there were 109 risks on the risk register relating to the medical service. Of these risks, 26 had a current risk rating of 15 or above (red rating); 58 had a current risk rating between eight and 12 (amber rating) Red rated risks included – nursing, medical and therapy staffing; suitable cover for the absence of the safeguarding adults lead; decontamination of endoscopy equipment at the Royal Hampshire County Hospital.

Systems for identifying risks were not effective. The risk register did not include the date risks were added to the risk register. This made it difficult to assess if risks were reviewed regularly. A review date was included on the risk register but it was not clear whether this was the date for the next review or the date the entry was last reviewed.

Not all risks relating to staffing were identified with mitigating actions in place. Overton unit was not included in the safer staffing report to the board of directors. This meant the trust could not have effective oversight of staffing on this unit.

We reviewed the last two meeting records of the medical services divisional quarterly health and safety meeting. We saw that risk issues relating to fire safety, security and estates were discussed at this meeting.

Senior staff we spoke with were clear about the risks to the service. The Medical Director and Operations Director described the current risks as staffing, decontamination, process around mental health act legislation.

Endoscopy services carried out regular audits to measure their performance and identify areas for improvement.

The service had an up to date Local Emergency Preparedness Resilience Policy (EPRR policy).

Information from the chief nurse review 2017 to 2018 showed that the trust did not have any hospital acquired pressure ulcer in the past 18 months. Following our inspection the trust stated that this was inaccurate and that pressure ulcers had reduced but did not provide data to support this.

Preventing pressure ulcer development was one of the campaign that staff had signed up to. The trust had invested in a new stock of pressure relieving mattresses which could be inflated to reduce pressure ulcer development targeted at the most vulnerable points on the body.

However, despite a high incidence of serious incident falls the trust did not have a falls risk action plan to mitigate the risk associated with patient falls.

Andover War Memorial Hospital

Not all the risks identified on inspection were included and it was not clear if risk registers were reviewed regularly.

We were not assured of the trust process for management of risk at Andover War Memorial Hospital, concerns regarding the management of medicines, resuscitation equipment and staff
knowledge of emergency escalation process. The risks we raised had not been recognised by the trust and therefore did not have actions in place to mitigate these risks.

The clinical and operational service lead for endoscopy confirmed that meeting joint advisory group (JAG) guidelines at the Andover site was not always possible and that all endoscopy lists were mixed sex lists. Despite this known non-compliance with JAG standards there were no mitigating actions in place to safeguard patients' privacy and dignity.

We were not assured the trust were recognising and working to mitigate mixed sex breaches at Andover War Memorial Hospital.

**Basingstoke and North Hampshire Hospital**

*Not all the risks identified on inspection were included and it was not clear if risk registers were reviewed regularly.*

Clinical matrons told us their top risks were staffing levels, pressure ulcers, and lack of pharmacy support. Lack of pharmacy support and pressure ulcers were not included on the medical divisional risk register. The trust told us that pressure ulcers were included on the speciality medicine risk register since 2014. The clinical matron we spoke with was not aware of how to access the risk register and commented that they would ask their manager how to access it.

**Royal Hampshire County Hospital**

*Not all the risks identified on inspection were included and it was not clear if risk registers were reviewed regularly.*

Not all risks we observed during the inspection were on the trust risk register. For example, the risk relating to multiple servicing stickers on equipment was not on the risk register with mitigating actions in place.

The risk we identified relating to use of multiple servicing stickers on equipment had been raised with the manual handling team by nursing staff on several occasions but no action had been taken and the known risk was not on the risk register. Therefore, despite the trust being aware of this risk no action had been taken to address it.

The Twyford stroke unit monitored performance with the use of the national SSNAP audit and took action to improve the service.

**Information management**

**Trust wide**

*The trust collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards.*

The service provided monthly data on staffing, quality and safety to be reviewed at board meetings.

The trust had a monthly data quality group which monitored data quality across the trust.

The trust had appointed a Chief Clinical Information Officer & Chief Nursing Information Officer in 2017. Their role was to lead on the digitalisation programme ensuring that our investment in IT is useful to patients and clinicians.

**Engagement**

**Trust wide**
The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. Patients were encouraged to complete regular surveys to provide feedback on the care they had received. Themes of concerns and complaints and feedback from the ‘friends and family test’ survey were reviewed regularly.

The trust had a staff engagement plan with detailed actions that followed on from the staff survey and included action to improve staff wellbeing and the culture.

The trust emailed a medical services newsletter to staff every month. We reviewed the June 2018 newsletter and saw it included, updates about service provision, celebration of staff achievements and learning from incidents.

In the last national NHS staff survey published in 2017 the trust had a response rate of 43% against national average response rate of 44%. Comparing the 2017 results for the trust to all acute trusts the engagement score, recommendation rates and communication were all higher than the national average. Rates of bullying and harassment were about the same when compared to all other acute trusts.

Andover War Memorial Hospital
The trust engaged well with patients, staff, and the public to plan and manage appropriate services.

The trust had an active staff recognition scheme called the Wow! awards. Staff we spoke with were positive about the recognition scheme and were proud to have been nominated and awarded a Wow! Award. Staff told us it was ‘lovely to be recognised for going above and beyond’

Basingstoke and North Hampshire Hospital
The trust engaged well with patients, staff, and the public to plan and manage appropriate services.

On the acute assessment unit, the clinical matron had introduced team meetings every two to three months. Staff we spoke with told us the main form of communication was via email and a social media page.

‘Shimmer and shine’ noticeboards were used to display positive feedback from patients about staff.

Royal Hampshire County Hospital
The trust engaged well with patients, staff, and the public to plan and manage appropriate services.

The stroke unit was engaging positively with patients and the public. Twyford ward stroke unit had been using social media to engage with patients and the public. Staff had been involved in charity fundraising events and the clinical matron hoped using social media would help raise the profile of the ward to recruit new staff.

The trust had an active staff recognition scheme called the Wow! awards. Staff we spoke with were positive about the recognition scheme.

On Twyford ward a local recognition scheme had been introduced. Staff could nominate a ‘stroke star’ from patients to staff members on the ward or other departments within the hospital weekly and the results were displayed on their board.
The clinical matron on Twyford was starting a ward away day week at the end of June 2018. These were planned over four dates and included about 45 staff members. These days aimed to support the diverse workforce, taking into account staff ethnicity, and diversity recreating scenarios and working through these as part of learning.

Learning, continuous improvement and innovation

Trust wide 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 trust had a quality improvement strategy 2018-2020 with the tagline ‘everyone is an improver’ the strategy aimed to empower all staff to get involved in projects to improve patient care.

Andover War Memorial Hospital

There was little evidence of service improvement or innovation

Basingstoke and North Hampshire Hospital

There was some evidence of learning and improvement.

The hospital was piloting a ‘hospital at night’ project. The pilot involved training night practitioners to triage calls from nursing staff to junior doctors. So far, the project had resulted in a 75% reduction in the number of calls to junior doctors which freed up their time to review the most unwell patients.

The cardiac department were involved in research work with the pharmacy team to introduce new therapies and treatments.

The service had implemented the ‘SAFER’ patient flow bundle using the ‘big room’ methodology. All medical staff were invited to a weekly meeting to discuss developing the methodology at the trust to improve patient flow and safe discharge of patients.

Royal Hampshire County Hospital

There was some evidence of learning and improvement.

The service had implemented the ‘SAFER’ patient flow bundle using the ‘big room’ methodology. All medical staff were invited to a weekly meeting to discuss developing the methodology at the trust to improve patient flow and safe discharge of patients.

The hospital had an outreach vascular service for acute and emergency referrals. Weekly ward rounds were carried out on the elderly care wards to review patients. The most commonly referred problems were foot ischaemia and diabetic foot problems. The hospital was part of Wessex Vascular network and published data every year as part of vascular services quality improvement programme (VSQIP).

Twyford ward had developed specific bedside folders for each bedside. These contained an array of information such as different type of strokes and its effects on patients and also clear information on medical terminology and its meaning. As part of a quality improvement project, the staff had access to red pillows which were used to identify and support the affected side of the body.
The stroke coordinator worked very closely with the emergency department (ED) and Twyford ward. A physiotherapist and a paramedic from the ED identified patients and ‘pulled patients’ from ED and transferred to the ward within four hours from admission to ED. This supported good patient outcomes for time critical thrombolysis treatment.
Facts and data about this service

The Hampshire Hospitals NHS Foundation Trust has three registered locations and located on three sites. The Andover War Memorial Hospital based at Alton, the Basingstoke and North Hampshire Hospital based at Basingstoke, and the Royal Hampshire County Hospital at Winchester.

Andover War Memorial Hospital
Andover hospital includes a 10-bedded day surgery unit with two operating theatres. It offers minor surgical procedures, dermatology, one-stop menstrual disorders clinic, one-stop flexible sigmoidoscopy service, cataract and minor eye surgery, urology, diagnostic and endoscopy. Surgeries that require general anaesthetic are not carried out at this hospital.

Basingstoke and North Hampshire Hospital
Basingstoke and North Hampshire Hospital includes the main theatre suit with seven theatres; the Diagnostic Treatment Centre (DTC) with four theatres and four endoscopy rooms and the Eye Day Care Unit (EDCU) with one eye theatre (local anaesthetic cases only). There is a pre-assessment unit. The surgical division also includes the following areas.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Number of beds</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2</td>
<td>18</td>
<td>Liver and Peritoneal Malignancy Ward</td>
</tr>
<tr>
<td>C3</td>
<td>23</td>
<td>Emergency Surgery Ward includes a 5 trolley Surgery Assessment Unit</td>
</tr>
<tr>
<td>C4</td>
<td>16</td>
<td>Elective Surgery Ward</td>
</tr>
<tr>
<td>D1</td>
<td>33</td>
<td>Elective Orthopaedic Ward</td>
</tr>
<tr>
<td>D3</td>
<td>24</td>
<td>Emergency Orthopaedic Ward</td>
</tr>
<tr>
<td>D4</td>
<td>22</td>
<td>Emergency Orthopaedic Ward</td>
</tr>
<tr>
<td>Wessex</td>
<td>11</td>
<td>Haemato-oncology Ward</td>
</tr>
<tr>
<td>DTC</td>
<td>12</td>
<td>Day cases and Short Stay Unit</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>148</strong></td>
<td></td>
</tr>
</tbody>
</table>

Royal Hampshire County Hospital
Royal Hampshire County Hospital includes the Nightingale theatres with four theatres and one eye theatre; The Treatment Centre/Short Stay Surgical Centre (SSSU) with three theatres and the Heathcote Theatres with two theatres. There is a pre-assessment unit. The surgical division also includes the following areas.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Number of beds</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wainwright ward</td>
<td>11</td>
<td>Elective Surgery Ward</td>
</tr>
<tr>
<td>Kemp Welch ward</td>
<td>17</td>
<td>Elective &amp; Emergency Surgery Ward includes a 6 trolley Surgery Assessment Unit</td>
</tr>
</tbody>
</table>
Basingstoke and North Hampshire Hospital (BNHH) / Royal Hampshire County Hospital (RHCH)

The trust runs a range of surgical services for inpatient and day case procedures including urology and peritoneal malignancy as well as services for hepatobiliary, upper gastrointestinal, colorectal, ear nose and throat (ENT), ophthalmology, orthopaedics, oncology, maxiofacial and oral surgery.

The urology department treats patients with the latest minimally invasive treatments for a variety of conditions including prostate cancer, bladder cancer, kidney stones and benign prostatic enlargement.

Colorectal has a range of services including laparoscopic colorectal cancer surgery, the hospital is a tertiary referral centre for peritoneal surface disease, and management of low rectal cancer.

The peritoneal malignancy unit at Basingstoke and North Hampshire Hospital is one of the largest peritoneal malignancy centres in the world, undertaking approximately 200 cytoreductions with hyper-thermic intraperitoneal chemotherapy (HIPEC) a year. The unit offered maximal tumour debulking, complete cytoreductions and active monitoring for patients referred in from around the UK.

The orthopaedic department provided a range of services across a number of sites. These include a full trauma service and elective inpatient on both main hospital sites (Basingstoke and North Hampshire Hospital and Royal Hampshire County Hospital). Outpatient services are also run from Basingstoke, Winchester, Alton and Andover. The team cover a range of sub-specialities including hand, shoulder, elbow, hip, knee, feet and spines. The department also runs the Tier 2 services for North Hampshire Clinical Commissioning Group (HCCG) with a musculoskeletal (MSK) service and a spinal MSK (Hampshire Backs) service.

Ear Nose and Throat (ENT) offer new technologies and diagnostic procedures including trans-nasal oesophagostomy for the investigation of high dysphagia, the use of lasers for the treatment of facial skin blemishes and the resection of head and neck cancers and modern phono-surgery techniques in the combined voice clinic.

Outpatients and chemotherapy services are delivered in Winchester and Basingstoke for the oncology and haematology departments, as well as an 11-bedded inpatient ward at Basingstoke.

(Source: Routine Provider Information Request (RPIR) – Acute Context)

Non-elective surgical services were currently provided across the two hospital sites at BNHH and RHCH. These non-elective admissions arose from direct Emergency Department (ED) walk in patients, inpatient referrals and GP referrals. Emergency surgical care was provided 24 hours a day, seven days a week on both sites, delivered by a clinical team who were free of elective commitments.

The trust had 34,186 surgical admissions from February 2017 to January 2018. Emergency

<table>
<thead>
<tr>
<th>Bartlett ward</th>
<th>27</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Cross ward</td>
<td>20</td>
</tr>
<tr>
<td>Emergency Orthopaedic Ward</td>
<td></td>
</tr>
<tr>
<td>Elective Orthopaedic Ward</td>
<td></td>
</tr>
<tr>
<td>Treatment Centre/SSSU</td>
<td>20</td>
</tr>
<tr>
<td>Day cases and Short Stay Unit</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>108</td>
</tr>
</tbody>
</table>
admissions accounted for 9,003 (26.3%), 19,571 (57.3%) were day case, and the remaining 5,612 (16.4%) were elective.

(Source: Hospital Episode Statistics)

We inspected Andover War Memorial Hospital on 12 June 2018 and completed a follow-up visit on 5 July 2018. We visited the day surgery unit, operating theatres and recovery area. We spoke with two patients and 14 staff which included doctors and nurses and observed the care and treatment patients were receiving. Before and after the inspection we reviewed performance information from and about the surgery service.

We inspected Basingstoke and North Hampshire Hospital on 13 June 2018. We visited main theatres, the pre-assessment unit, C2, C3, C4, D1, D2, D4, DTC, EDCU and the Candover clinic. We spoke with approximately 11 patients, relatives/visitors and 78 members of staff that included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, dieticians, therapists, pharmacists, pharmacist assistants and senior management. We observed the care and treatment patients were receiving and reviewed 10 patient records. Before and after the inspection we reviewed performance information from and about the surgery service.

We inspected Royal Hampshire County Hospital on 14 June 2018. We visited theatres, the pre-assessment unit, Wainwright ward, Kemp Welch ward, Bartlett ward, St Cross ward, and the Treatment Centre / SSSU. We spoke with approximately 13 patients, relatives/visitors and 54 members of staff that included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, dieticians, therapists, pharmacists, pharmacist assistants and senior management. We observed the care and treatment patients were receiving and reviewed 20 patient records. Before and after the inspection we reviewed performance information from and about the surgery 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 service provided mandatory training in key skills to all staff but failed to make sure everyone was completing it.

Trust wide mandatory training completion rates

The trust set a target of 80% for completion of mandatory training, with the exception of information governance module which had a target of 95%. Furthermore, the trust did not provide targets for immediate life support and medicine management training modules.
A breakdown of compliance for mandatory courses from April 2017 to February 2018 for medical/dental and nursing staff in surgery is shown below:

**Mandatory training completion by module – medical and dental staff**

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; safety</td>
<td>222</td>
<td>271</td>
<td>81.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>202</td>
<td>271</td>
<td>74.5%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>179</td>
<td>271</td>
<td>66.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling</td>
<td>178</td>
<td>271</td>
<td>65.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>146</td>
<td>227</td>
<td>64.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>173</td>
<td>271</td>
<td>63.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Counter fraud</td>
<td>170</td>
<td>271</td>
<td>62.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>166</td>
<td>271</td>
<td>61.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>120</td>
<td>265</td>
<td>45.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>64</td>
<td>271</td>
<td>23.6%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>29</td>
<td>271</td>
<td>10.7%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>20</td>
<td>271</td>
<td>7.4%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,669</strong></td>
<td><strong>3,202</strong></td>
<td><strong>52.1%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust target was met for one of the 10 mandatory training modules shown above for medical staff, which was the health and safety module with 81.9%. Of the modules where a target was set, dementia training module had the lowest completion rate with 23.6%. Of the modules where a target was not provided, medicine management and immediate life support training modules had low completion rates of 10.7% and 7.4% respectively.

**Mandatory training completion by module – nursing staff**

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counter fraud</td>
<td>367</td>
<td>408</td>
<td>90.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>367</td>
<td>408</td>
<td>90.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire</td>
<td>340</td>
<td>408</td>
<td>83.3%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>338</td>
<td>408</td>
<td>82.8%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>336</td>
<td>406</td>
<td>82.8%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>318</td>
<td>408</td>
<td>77.9%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>312</td>
<td>408</td>
<td>76.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling</td>
<td>310</td>
<td>408</td>
<td>76.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>276</td>
<td>396</td>
<td>69.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>256</td>
<td>408</td>
<td>62.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>157</td>
<td>403</td>
<td>39.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>45</td>
<td>401</td>
<td>11.2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,422</strong></td>
<td><strong>4,870</strong></td>
<td><strong>70.3%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust target was met for five of the 10 mandatory training modules shown above for nursing staff. Of the modules where a target was set, dementia training module had the lowest completion rate with 62.7%. Of the modules where a target was not provided, medicine management and immediate life support training modules had low completion rates of 39.0% and 11.2% respectively.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Andover War Memorial Hospital
Staff we spoke with told us they had enough time to complete mandatory training courses. Mandatory training was a mixture of face to face and online training.

The trust provided trust wide mandatory completion data. Therefore, we could not see the compliance rates for the day surgery unit.

Basingstoke and North Hampshire Hospital
We were told by senior staff it was a challenge to release staff to complete their mandatory training due to lack of time, if they did release staff it would leave staffing levels reduced on the wards.

A clinical matron we spoke with told us there had been problems with the availability of basic life support (BLS) training courses across the trust meaning staff were no longer in date with their training. This had been escalated and the trust were looking into providing additional training.

Royal Hampshire County Hospital
We were told by senior staff it was a challenge to release staff to complete their mandatory training due to lack of time, if they did release staff it would leave staffing levels reduced on the wards.

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Safeguarding
Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, medical staff compliance with training on how to recognise and report abuse was low.

Safeguarding training completion rates

The trust set a target of 80% for completion of safeguarding training.

A breakdown of compliance for mandatory courses from April 2017 to February 2018 for medical/dental and nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children</td>
<td>186</td>
<td>271</td>
<td>68.6%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>156</td>
<td>271</td>
<td>57.6%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>342</td>
<td>542</td>
<td>63.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 80% target was not met for either safeguarding training modules for which medical staff in surgery were eligible. Safeguarding adults had the lowest completion rate with 57.6%.
Safeguarding training completion by module – nursing staff

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>348</td>
<td>408</td>
<td>85.3%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children</td>
<td>324</td>
<td>408</td>
<td>79.4%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>672</td>
<td>816</td>
<td>82.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 80% target was met for safeguarding adults for which nursing staff in surgery were eligible. However, safeguarding children training module was slightly below the target with 79.4%.

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

Trust wide

We reviewed the trust safeguarding training completion rates but there was no information submitted on the level of safeguarding training for adults and children. The lead for safeguarding children should be trained to level four.

We reviewed the trust safeguarding adult’s policy and saw it was up to date, due for review in August 2019. The policy outlined staff responsibilities, the reporting process for a safeguarding concern and included staff duties in relation to reporting female genital mutilation (FGM).

The trust had safeguarding clinical leads for children and for adults and they worked closely with the trust’s safeguarding team.

The trust’s governance arrangements for safeguarding children include a quarterly safeguarding children forum with representation from key clinical areas. The designated safeguarding children’s nurse from Hampshire clinic commissioning group (CCG) West was also invited. The safeguarding children team provided quarterly reports to Hampshire CCG’s as part of contract monitoring.

The Safeguarding Adults Committee met each quarter. The associate director for governance chaired the committee and represented the trust at the Safeguarding Adults Board for Hampshire (HSAB). Each quarter a report was provided to the CCG as part of the contract monitoring. This report was also shared with the trust board of directors and executive committee. The executive committee and board of directors received twice yearly reports on safeguarding adults and safeguarding children from the named safeguarding professionals.

There was a Safeguarding Adults page on the intranet that was kept up to date with information and policy for staff.

Andover War Memorial Hospital

Staff we spoke with demonstrated an awareness of the signs of abuse and understood the safeguarding reporting process. Staff told us they would escalate safeguarding concerns to the nurse in charge or clinical matron and speak with the safeguarding lead if they needed advice.

Staff we spoke with said they would report safeguarding concerns through the electronic reporting system.

Staff we spoke with knew how to contact the trust safeguarding leads for advice and could give us examples when they had.
Basingstoke and North Hampshire Hospital

Staff we spoke with demonstrated an awareness of the signs of abuse and understood the safeguarding reporting process. Staff told us they would escalate safeguarding concerns to the nurse in charge or clinical matron and speak with the safeguarding lead if they needed advice. Staff said they would report safeguarding concerns through the electronic reporting system.

Staff knew how to contact the trust safeguarding leads for advice.

The Diagnostic Treatment Centre (DTC) displayed a safeguarding poster with contact numbers for the safeguarding team and services in their reception area.

Royal Hampshire County Hospital

Staff we spoke with demonstrated an awareness of the signs of abuse and understood the safeguarding reporting process. Staff told us they would escalate safeguarding concerns to the nurse in charge or clinical matron and speak with the safeguarding lead if they needed advice.

Staff we spoke with said they would report safeguarding concerns through the electronic reporting system.

Staff we spoke with knew how to contact the trust safeguarding leads for advice and told us they were supportive.

Cleanliness, infection control and hygiene

Trust wide mandatory training data for infection prevention and control

Compliance with infection control mandatory training April 2017 to February 2018 for medical/dental and nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Course name</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental staff</td>
<td>Infection Control</td>
<td>166</td>
<td>271</td>
<td>61.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>Infection Control</td>
<td>318</td>
<td>408</td>
<td>77.9%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

An infection prevention control report was presented to the trust board twice a year. We reviewed the infection prevention and control report presented to the board in November 2017 and found the trust set a target of no more than 34 cases of clostridium difficile (c. difficile) in the year April 2017 – March 2018. As of the end of October 2017 there had been 16 cases of reportable hospital acquired c. difficile and 29 non-reportable cases. The hospital acquired MRSA bacteraemia target for April 2017 – March 2018 was zero and to date there had been no cases. There were eight cases of MSSA bacteraemia between April and October 2017.

Andover War Memorial Hospital

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
All clinical areas we visited were visibly clean, tidy and free from dust. We saw daily cleaning checklists were consistently completed on the day unit and in theatres. The day unit was cleaned Monday to Friday in the evening once it had closed for the day. There was no cleaning at the weekend as the unit was closed.

Disposable curtains used in patients’ areas were clean and labelled to show dates of their last change. We were told that curtains were changed every three months or more frequently if they became soiled. The trust's infection control policy say curtains should be changed at least every six months or more frequently if needed.

Theatre changing rooms were clean and tidy with scrubs stored neatly. We observed staff correctly dressed for theatres in line with the trust’s uniform policy. We observed nursing staff arranging for appropriate shoes to be found for a workman carrying out repairs in the department.

We observed staff cleaning beds and equipment after patients had been discharged from the recovery area. However, beds were not labelled as clean and ready for use after this.

All staff we saw in the day surgery unit were bare below the elbow in line with trust policy. This was to promote more effective hand washing and to reduce the spread of infection. We saw posters explaining the World Health Organisation (WHO) ‘five moments for hand hygiene’ in the staff room.

Personal protective equipment (PPE), such as gloves and aprons, were available for staff in all areas where it was necessary. We saw staff using PPE appropriately.

Hand sanitiser gel was available at the entrance to the day surgery unit, at appropriate places round the day unit and at the end of each bed in the recovery area.

The unit collected infection prevention and control (IPC) data in the form of hand hygiene audits and infection control audits and we saw evidence of this. Data supplied by the trust showed from December 2017 to May 2018, for three months the day surgery unit had hand hygiene results of 100%. However, for the months of December 2017, February 2018 and March 2018 no audit data had been submitted.

As per the trusts infection control policy, we saw the use of ‘I am clean’ stickers in the day surgery unit. Equipment was labelled and dated so staff knew items were clean and ready to use.

**Basingstoke and North Hampshire Hospital**

Not all areas we inspected controlled infection risks well.

Dedicated housekeeping staff were allocated to a certain ward. We were told by staff this gave them ownership for the areas they worked in and helped develop good relationships with both staff and patients. We saw cleaning staff on the surgical wards we visited, and most of the surgical areas we visited were visibly clean, tidy and free from dust. However, we did find high and low areas of dust in theatre 3 and the ophthalmic day theatre anaesthetic room. A dirty surgical environment posed a higher risk of surgical site infections (SSIs) post-surgery. SSIs are the most common cause of surgical complications. The trust monitored SSI trends. Orthopaedic SSI data for the Basingstoke site showed although SSI rates were mostly better than the national average infection rate, in certain types of surgery the rate had increased over the last year.

The wards used disposable privacy curtains and we saw they were changed in line with the trust policy. Disposable curtains used in patient areas were clean and labelled to show dates of the last change. Curtains were changed every six months or more frequently if they became dirty or contaminated. This was in line with the trust’s infection control policy.
Theatre changing rooms were clean and tidy with scrubs stored neatly. We observed staff correctly dressed for theatres in line with the trust’s uniform policy.

Staff in the service were bare below the elbow in line with trust policy. This was to promote more effective hand washing and prevent the spread of infection.

Personal protective equipment (PPE), such as gloves and aprons, were available for staff in all areas where it was necessary. We saw staff using PPE appropriately. Staff followed handwashing procedures in accordance with the World Health Organisation (WHO), ‘five moments for hand hygiene’.

Hand sanitiser gel was available at the entrance to wards and at other appropriate positions in the clinical areas.

We were told by ward staff beds were cleaned regularly. However, when we reviewed the bed cleaning schedule paperwork on C3 and D3 wards they had not been filled out. This meant there was no assurance cleaning had taken place. Staff we spoke with on the pre-assessment unit told us patient weighing scales and screening equipment were not cleaned between patients this was not in line with the trust’s infection control policy which stated that equipment should be cleaned between patients.

As per the trust’s infection control policy, we saw the use of ‘I am clean’ stickers throughout the surgery wards and departments. Equipment was labelled and dated so staff knew items were clean and ready to use. All commodes we inspected were clean.

On the surgical wards patients who had or were at risk from infections were appropriately segregated in single rooms.

On the pre-assessment unit the toilet in the sluice room, intended as a sample collection toilet, was used as the general patient toilet. This was not best practice as it increased the risk of sample contamination.

We observed theatre 3 had a broken door, it had been assessed by the infection control team that it was a risk but had not been repaired and the theatre was still in use. Additional information supplied by the trust after the inspection informed us the estates team had reviewed the door and a new door was on order. Airflow had been altered in the theatre to accommodate the damaged door and this met with the building requirements. At the time of inspection the door was an infection risk to patients and staff.

During our inspection, we noticed sinks in the surgery areas were not complaint to HBN00-10 Part C, for example theatre 3 hand hygiene sink; ophthalmic day theatre, anaesthetic room. Within the same area, we observed a sink with limescale on the taps and worktops were chipped and damaged with bare wood showing, making effective cleaning difficult.

The service collected infection prevention and control (IPC) data in the form of hand hygiene audits and infection control audits and we saw evidence of this. Data supplied by the trust showed from December 2017 to May 2018, the majority of wards, theatres and clinical areas had hand hygiene results of 100% however, some areas of the Diagnostic Treatment Centre (DTC) had results of 80% with the DTC theatre recovery ward being consistently at 80% for the six months. D4 ward had results of 40% and 60% for January 2018 and March 2018 respectively.

We reviewed results from the infection prevention and control environment audit for wards D1, D3, and D4. These audits gathered information from the in/out patient areas; such as cleanliness of beds, mattresses, pillows, chairs, lockers, call bells, curtains: equipment; such as PPE, stored equipment, resuscitation trolleys, sharps bins: and utility rooms to make sure there were paper towels, hand hygiene poster, waste bin, alcohol based hand rub bottles, no inappropriate items in
the dirty room/sluice. Results from these audits showed the wards were either fully or partially compliant and infection control standards did not fall below the minimum compliance rate of 75% or below.

We observed in the pre-assessment unit items were inappropriately stored on the floor. In theatre 3 the clinical waste bins did not meet with infection control and prevention guideline and NICE guidance. The clinical waste bins were not fitted with appropriate lids. The sharps bins were overflowing and posed high infection control risks and needle stick injury. Sharps management did not comply with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff did not follow guidance on sharps management as the sharp bins were not clearly labelled and tagged to ensure appropriate disposal and to prevent risk of cross infection.

The surgical wards reported on Saving Lives: high impact interventions. The Saving Lives programme was introduced to support healthcare providers to reduce hospital acquired infections. It identified seven high-impact interventions relating to areas of clinical practice where patients were at increased risk of infection these included, monitoring the care of intravenous catheters and ongoing catheter care. The results for Basingstoke and North Hampshire hospital showed in May 2018, four out of the six wards scored below 85% for the elements of care for intravenous catheters. This was below the trust target of 90%. We were unsure if action plans had been put in place for underperforming wards.

The trust monitored MRSA and Clostridium difficile. Elective surgery patients were screened and needed to be MRSA free before being admitted.

We saw on the pre-assessment unit iodine and chlorhexidine, substances used in operations, were tested on patients to make sure they were not allergic to them. An amount of each substance was decanted from a bottle into a tub at the start of the day. This tub was used for the whole day and not replaced between patients. This was not best practice as the substances were open to the elements and infections could be passed between patients.

The trust took part in PLACE (Patient-led assessments of care environment). These were annual assessments involving local people who went into hospitals to assess how the environment supported the provision of care. The trust provided us with PLACE results for three of the surgical wards, C2, C4, D1 and the diagnostic treatment centre from 2018 inspections. Each of the assessments showed that on first and second assessment patients were either confident or very confident about the ward environment.

Royal Hampshire County Hospital

Not all areas we inspected controlled infection risk well.

Most of the areas we visited were visibly clean, tidy and free from dust. However, we saw that the anaesthetic room in the pain management theatre was below infection control standards with dusty resuscitation equipment, felt notice boards, non-compliant sink and open bins. On Wainwright ward we saw dusty resuscitation equipment and equipment stored on the wards making it cluttered. In some theatre areas we visited there were boxes on top of cupboards and on the floor making these areas harder to clean effectively. A dirty surgical environment posed a higher risk of surgical site infections (SSIs) post-surgery. SSIs are the most common cause of surgical complications. The trust monitored SSI trends. Orthopaedic SSI data for the Winchester site showed SSI rates were worse than the national average infection rate in certain types of surgery. Although infection rates had greatly reduced in some area of surgery (total knee replacement) since 2015.
The wards used disposable privacy curtains and we were told by nursing staff they were changed every six months or more frequently if they became dirty or contaminated. Staff were unsure how often they should be changed according to trust policy but thought it was every six months. Disposable curtains used in patient areas were clean and labelled to show dates of the last change.

Theatre changing rooms were clean and tidy with scrubs stored neatly. We observed staff correctly dressed for theatres in line with the trust’s uniform policy.

Most staff in the service were bare below the elbow in line with trust policy. This was to promote more effective hand washing and to reduce the spread of infection. However, we did observe two doctors working clinically wearing their ties and without their shirt sleeves rolled up.

Personal protective equipment (PPE), such as gloves and aprons, were available for staff in all areas where it was necessary. We saw staff using PPE appropriately.

Hand sanitiser gel was available at the entrance to wards and at other appropriate positions in the clinical areas.

As per the trust’s infection control policy, we saw the use of ‘I am clean’ sticker in most of the surgery wards and departments. Equipment was labelled and dated so staff knew items were clean and ready to use. All commodes we inspected were clean.

On the surgical wards patients who had or were at risk from infections were appropriately segregated in single rooms.

During our inspection, we noticed sinks in the surgery areas were not compliant to HBN00-10 Part C, for example in the anaesthetic room of the pain management theatre.

We saw peeling paintwork on Wainwright ward. Staff informed us that this had been highlighted as a risk and was on the risk register. As dates were not added to the risk register we were unsure how long it had been on the risk register for.

The service collected infection prevention and control (IPC) data in the form of hand hygiene audits and infection control audits and we saw evidence of this. Data supplied by the trust showed that from December 2017 to May 2018, the majority of wards, theatres and clinical areas had hand hygiene results of 100% with only Bartlett ward having results of 80% in December 2017.

We reviewed results from the Infection prevention and control environment audit for Wainwright ward. These audits gathered information from the in/out patient areas; such as cleanliness of beds, mattresses, pillows, chairs, lockers, call bells, curtains: equipment; such as PPE, stored equipment, resuscitation trolleys, sharps bins: and utility rooms to make sure there were paper towels, hand hygiene poster, waste bin, alcohol based hand rub bottles, no inappropriate items in the dirty room/sluice. Results from this audit showed the ward was partial compliance for in/out patient areas and utility rooms however equipment was not compliance with a score of 55%. This showed that the infection control standards fell below the minimum compliant rate of 75%. During our inspection whilst on Wainwright ward the medicine waste container was over full with medicine waste brimming over the top.

The surgical wards reported on Saving Lives: high impact interventions. The Saving Lives programme was introduced to support healthcare providers to reduce hospital acquired infections. It identified seven high-impact interventions relating to areas of clinical practice where patients were at increased risk of infection these included, monitoring the care of intravenous catheters and ongoing catheter care. The results for Royal Hampshire County Hospital monthly hygiene audit for
catheter ongoing care showed that in March 2018 surgery wards achieved 38% compliance and orthopaedic wards 50%; for April 2018 it was 58% and 82% respectively and for May 2018 it was 56% and 60% respectively. For the period May 2017 to April 2018 the trust catheter ongoing care audit results ranged from 50% to 84% with an average of 69%. This was below the trust target of 90%. The trust’s Patient Safety Group had been asked to explore the reasons for this performance and to develop an action plan.

(Source: Board papers May 2018)

The trust monitored methicillin-resistant staphylococcus aureus (MRSA) and MSSA in line with the trust’s infection control policy. MRSA is a type of bacterial infection which is resistant to antibiotics and can cause harm to patients. Elective surgery patients were screened and needed to be MRSA free before being admitted.

The trust took part in PLACE (Patient-led assessments of care environment). These were annual assessments involving local people who went into hospitals to assess how the environment supported the provision of care. The trust provided us with PLACE results for two of the surgical wards, Bartlett and St Cross, from 2018 inspections. Assessments for Bartlett ward showed that on first and second assessment patients were either confident or very confident about the ward environment. Assessments for St Cross ward showed that on first assessment patients were not very confident and confident on second assessment.

Environment and equipment

Andover War Memorial Hospital

The service had suitable premises but did not always use them appropriately or maintain them well. Equipment was not always well maintained.

The day surgery unit was open from 8am to 6pm Monday to Friday. There was a manned reception desk from 9am to 4pm. Outside of these hours patients would buzz through to clinical staff to gain access to the unit.

There was a pleasant waiting room, with appropriate chairs, reading material and a television. The room could get hot but a fan had been provided to keep patients cool.

The unit was spacious and airy. The unit had two theatres and space for 10 trolley facilities. On the day of our inspection there were six beds on the unit.

Male and female patients were not segregated in separate areas, and the unit operated mixed sex lists on all days. We were told by staff they would mitigate against mix sexed breaches by informing patients the recovery area would be mixed sexed, they would ask male patients to keep their vests on and they would use the blue disposable curtains if needed. The trust had not declared any mixed sex breaches in the past year.

The trust provided with the annual inspection and re-verification reports for the ventilation systems used in theatres. These reports made sure that the minimum standards of the Department of Health Publication: Health Technical Memorandum 03:01: Specialised ventilation for healthcare premises were met. Overall the ventilation systems were in date and in adequate working condition, there were recommendations made at the end of the report. We did not ask to see the action plans for these recommendations.

The unit did not have facilities to sterilise equipment. Dirty equipment was sent to Royal Hampshire County Hospital at Winchester. Staff confirmed equipment was returned and available to them when needed.
A random check of equipment showed equipment was overdue for testing for example four of the dinamap vital sign monitors had labels showing the equipment should have been retested by 20/04/2018 and the hoist was 03/08. In addition, equipment in the recovery room and throughout the department either had out of date electrical testing labels or no labels to know if equipment had been tested.

There was a fire extinguisher next to the exit door to the outside in the waiting area of the unit. There was a curtain on the door, this curtain was draped behind the cannister so the equipment was visible. However, if the curtain was to return to its natural position it would cover the fire extinguisher, the emergency patient call button and fire evacuation alarm point meaning it would be hard to see/find in times of emergency.

The day surgery unit shared its resuscitation equipment with the birthing centre at Andover War Memorial hospital. The resuscitation equipment was stored in the unit during the day and once the last patient had left the unit at 6pm the equipment would be taken to the birthing centre where it would remain overnight. It would be brought back to the day surgery unit usually before the first patient arrived. The senior nursing staff at the unit told us if the resuscitation equipment was not there in the morning they would phone the birthing centre to ask for the equipment to be brought over to them. We were told that the day surgery unit checked the equipment, it was not checked whilst it was at the birthing centre and this was confirmed by a nurse we spoke to in the birthing centre and documentation we reviewed. As the day surgery unit was closed at the weekends, the resuscitation equipment was taken to the birthing centre at 6pm on a Friday, remained at the birthing centre for the weekend and was brought back to the day surgery unit on a Monday morning. There was no assurance that equipment would be fit for purpose as checks were not always checked out. There seemed to be a lack of responsibility and no clear policy of whom should return the equipment.

Although staff called the resuscitation equipment the resuscitation trolley it was in fact a grab bag that sat on a ward trolley for ease of moving to and from the birthing centre. The grab bag contained emergency drugs in the front pocket of the bag, this pocket was secured with a tamper proof tag. Therefore, daily checks did not include checking these drugs. They would only be checked if the tag had been tampered with. In addition to the grab bag, on a separate shelf there were two separate anaphylaxis drug boxes, these were not tamper proof and it was unclear if these were checked regularly, there was also a suction machine, and a defibrillator. An oxygen cylinder was on a separate trolley that sat next to the rest of the emergency equipment.

We asked staff on the day surgery unit what they would do in an emergency. Staff seemed unsure of the process and were also unsure which parts of the emergency equipment they should take with them. We were also told that if two staff members responded to the emergency, the second responder would take an endoscopy bed with them as this had an oxygen bottle attached to it.

It was unclear what level of emergency response was being offered at the day surgery unit and wider hospital and staff seemed unsure of their responsibilities. There was no emergency crash team on the Andover site, therefore staff would call 999 and carry out basic life support until the ambulance arrived. It was unknown if staff training included defibrillator training. However, in addition to calling 999 staff also needed to call 2222 to alert bleep holders to attend the emergency. Staff were unsure if they were required to call 2222 out of hours. We were told that staff from different areas of the Andover site carried bleeps. Although staff, including staff that carried the bleep, did not know how many bleep holders there were in total across the site, but thought it was about six to eight. The call went through to the switch board at the Royal Hampshire County hospital at Winchester and from there they would alert the Andover bleep holders.
When we asked staff in the day surgery unit and from around the hospital, including bleep holders, staff were unsure who should be carrying the bleep, what level of life support training they should have and what their responsibilities were. We could find no policies in regard to bleep holders and their role and responsibility and the level of training they were required to complete. Some nurses were trained in immediate life support which meant they were trained to intubate and administer drugs. However, nursing staff we spoke with said they would not attempt this. We were also told that not all bleep holders attended if the bleeps went off but it was hoped that someone would. When we spoke with nursing staff in the birthing centre they didn’t carry the bleep, it was in their main office, and if it went off no one would respond to it.

We saw laminated sheets that explained that staff needed to call 999 and 2222 to alert others to the emergency. However, staff needed to call 9 to get an outside line, so needed to call 9 999 to get the emergency services. This was the same to get through to the switch board at Winchester hospital, where staff needed to dial 2 to get through, so needed to call 2 2222. This information was not on the documentation and we were told there had been an incident when a staff member had got confused with the number they had to dial.

During the inspection we spoke to the clinical director for critical care and anaesthetics and the operational service manager responsible for the day surgery unit and asked about the emergency procedures at the unit. They were unsure of policies and procedures or how staff needed to respond. We were not assured that they had oversight of emergency procedures.

During the inspection we also spoke with the chair of the resuscitation committee about the emergency procedures at the day surgery unit and the wider Andover hospital. They were unclear of the procedures and had never worked at the Andover site therefore were unclear of the equipment or resources there. We were advised by the chair to speak with other members of the resuscitation team for clarification of policies and procedures, equipment and checks carried out by staff on the front line and audits carried out by the resuscitation team at the Andover site. Unfortunately, these members of staff were unable to talk with us. From this conversation we were not assured that the resuscitation team had oversight of the emergency procedures at Andover War Memorial hospital.

We could find no evidence that risk assessments had been carried out in regard to emergency procedures and response times.

We alerted the chief executive team of our concerns and unsafe working practices with regards to emergency equipment and responding to patient’s emergencies at the Andover hospital site during the inspection.

We revisited the day surgery unit three weeks later to carry out a follow up inspection and looked at the emergency equipment again. We saw evidence that following our previous visit the equipment had been reviewed by the resuscitation team. Documentation had been changed, there was a new laminated sheet with the correct contact telephone numbers. However, it was not site specific so could still lead to confusion. There were new daily check lists, although there were still missing checks at the weekend; although the equipment was in use at the birthing centre. Life support sessions were being arranged for staff but there was still some confusion as to what level this needed to be. Nursing staff we spoke with in the day surgery unit and the wider hospital were still confused about their responsibilities, the bleep holders and basic procedures.

During the unannounced inspection visit we spoke with a member of the resuscitation team who had come to visit the site and check the resuscitation equipment. We were told that the team had previously not known about the bleep system at the Andover site and had plans to review the system. They planned to carry out a risk assessment of the site, offer more training for staff and
carry out scenario training but we were given no timescale of when this would happen. However, we were still not assured there was a robust, safe emergency system at Andover War Memorial hospital.

**Basingstoke and North Hampshire Hospital**

The service did not always have suitable premises and equipment was not always looked after well.

The trust provided with the annual inspection and re-verification reports for the ventilation systems used in theatres. These reports made sure that the minimum standards of the Department of Health Publication: Health Technical Memorandum 03:01: Specialised ventilation for healthcare premises were met. Overall the ventilation systems were in date and in adequate working condition, however, there were recommendations made at the end of the report. We did not ask to see the action plans for these recommendations.

Facilities and surgical equipment were mainly fit for purpose and in line with professional guidance. However, some areas needed refurbishing and required facilities to be updated. For example, we saw many of the sinks in the theatre areas were non-compliant with NHS Health Building Notes; we observed wooden surfaces and peeling paint in the ophthalmic day surgery theatre area, and non-compliant waste bins in theatre 3. Most of the wards were free from clutter and equipment in the corridors. However, when we inspected C4 ward, we found equipment stored in the corridor which made the area seem cramped and not easy for patients to manoeuvre along.

The Diagnostic Treatment Centre (DTC) had single sexed changing rooms however the recovery area was mixed sex. In addition, the surgical assessment unit (SAU) situated on ward C3 and the pre-assessment unit had no physical space for separating sexes. Both the DTC and SAU operated mixed sex lists on all days. However, the trust had not declared any mixed sex breaches in the past year.

Concerns were raised by staff on D3 and D4 wards regarding their call bell system. Currently the only way they had to determine if a bell was ringing on their ward was by the loudness of the buzzer. Staff told us if it was loud they assumed to be from their ward if quieter than it was assumed to be on the other ward. From patient experience information the trust received we saw that there had been complaints from patient about delays in nurse attendance when call bells had been pressed.

A random check of equipment showed not all equipment was in date for its safety testing or had labels to show if equipment had been tested, for example the wheelchair on C2 was last serviced 05/02/16, Equipment throughout the eye care department unit either had out of date electrical testing labels or no labels. This posed risks to the safety of patients as the staff could not be assured the equipment is fit for purpose.

Equipment used for bariatric services and occupational therapy were available and staff told us it was easily accessible via the hospital stores.

Staff told us purchasing equipment could be a problem due to the financial constraints of the trust. We were also told getting equipment repaired could take a long time. Staff we spoke with told us there was not always enough equipment to offer an effective service. For example, the hospital only had one bladder scanner which was needed by many areas in the service and there was only one greenlight laser which was used in prostate treatment. This meant there could be delays to treatment due to lack of availability of these pieces of equipment.
Resuscitation trolleys were accessible on the wards, although the pre-assessment unit had no resuscitation equipment of its own and shared the resuscitation equipment with D3 and D4 ward. A check of resuscitation equipment found the daily checks were not always being carried out which meant it could not be assured equipment was there or fit for purpose if needed in an emergency. When we inspected the anaesthetic machine in theatre 3 we found daily checks were not always carried out. During our inspection we found that resuscitation trolleys were not universal across the hospital, which could lead to confusion if the trolleys needed to be used in an emergency. In addition, not all resuscitation trolleys had the same safety check schedules. Trolleys with tamper proof seals were deemed to only need weekly checking (D3 ward), whilst trolleys without tamper proof seals required daily checking (C2 ward).

Royal Hampshire County Hospital

The service had some appropriate equipment; however, there were some equipment which were in poor state of repair.

The trust provided with the annual inspection and re-verification reports for the ventilation systems used in theatres. These reports made sure that the minimum standards of the Department of Health Publication: Health Technical Memorandum 03:01: Specialised ventilation for healthcare premises (HTM03-01) were met. Overall the ventilation systems were in date and in adequate working condition, there were recommendations made at the end of the report. We did not ask to see the action plans for these recommendations. We were told that theatre 7 was not compliant with the HTM03-01 and had been put on the risk register.

Most of the facilities and surgical equipment were fit for purpose and in line with professional guidance. We found Nightingale theatre was bright, airy and modern looking. The wards we visited were clutter free, with minimum equipment stored in the corridors. However, staff told us about and we observed areas of concern on Wainwright ward; there was a broken and unsuitable shower chair which was still in operation, lack of space between the beds in Bay B and a generally cluttered ward environment. The pain management theatre had equipment stored in the corridors. We were told the surgical assessment unit had no storage area for equipment.

The waiting room in the pre-assessment unit, which was a large space with plenty of seating with low back chairs with arms. However; the unit had no facilities to cater for bariatric patients and there were no high back chairs.

In the treatment centre we saw hooks that were not non-ligature hooks. When we spoke with the nurse in charge we were told new hooks had been requested as this was a risk to patients. However, it had not been actioned.

We observed staff looking at electrical safety testing dates on equipment in the theatre suite.

The environment in the surgical assessment unit (SAU) and the pre-assessment unit was not appropriate as male and female patients were accommodated side by side. No mixed sex breaches had been declared.

Resuscitation trolleys were accessible on the wards and the pre-assessment unit. A check of resuscitation equipment found the daily checks were completed on most of the wards. However, Wainwright ward was missing daily checks, six in November 2017, two in January 2018, seven in February 2018, two in March 2018, one in May 2018, and three so far in June 2018. In addition, the trolley was not clean, the oxygen cylinder was stored inappropriately on the floor and the defibrillator was plugged into an extension cable.
Assessing and responding to patient risk

Andover War Memorial Hospital

We were told by staff there was no formal pre-assessment of patients except for cataract surgery patients. Patients having cataract operations would go to the Royal Hampshire County hospital at Winchester for their pre-assessment. The day surgery unit took low-risk patients and the suitability for patients attending the unit was determined by the consulting doctor in outpatients or by the referring GP.

The day surgery unit was only equipped to carry out procedures under local anaesthetic, regional block and sedation as there were no piped gases in the unit. This meant surgery needing general anaesthetic were not carried out in the unit.

The five steps to safer surgery was used by the hospital, which included the World Health Organisation (WHO) surgical safety checklist. The safety checklist is a recognised tool developed to help prevent the risk of avoidable harm and errors during and after surgery and should include safety-briefing, sign in, time out, sign out and debriefing. On the days we inspected the day surgery unit there were no general surgical lists operating only endoscopy and gastroscopy procedures. We observed several of these procedures and a modified WHO checklist was used. This modified WHO checklist did not include the fifth step, debriefing. We were told by theatre staff that trust-wide the fifth step was not formally carried out and therefore not documented. We were told by the nurse in charge that any issues were flagged during the list or discussed at the end of the list.

We were told by nursing staff patients who had received sedation as part of their procedure were monitored. However, the unit did not routinely use any tool such as the national early warning scores (NEWS) to identify deteriorating patients. This meant staff did not have a consistent escalation process they followed to ensure prompt access to medical support. On speaking with staff they told us they had NEWS forms on the unit but would only start to use them if they felt a patient was deteriorating to the point they needed emergency intervention. This meant that prompt action and escalation were dependent on the level of staff’s experience and skills which may pose further risks to patients’ safety. There were no audits of observations of WHO checklists in order to identify gaps in their applications and to mitigate these risks.

There were no consultants or anaesthetists based at the hospital, they would travel to the hospital to carry out their surgical lists. This meant there was not always the appropriate trained staff at the unit to administer medical treatment in an emergency. If patients needed emergency care, basic life support would be carried out by nursing staff, an ambulance called and the patient would be transported to either Basingstoke and North Hampshire hospital (BNHH) or Royal Hampshire County hospital (RHCH).

There were current in date standard operating procedures in place at the day surgery unit for deteriorating patients. These included; escalation of collapsed patient’s policy, the recognition of the deteriorating patient and the trust wide cardiopulmonary resuscitation policy. Staff we spoke with were unsure of the procedure for dealing with patient’s emergency. This included which emergency number to call, how to alert the bleep holder and equipment to take to administer basic life support. Staff told us they had been advised to take an endoscopy bed with them as this had oxygen attached to it. However, this bed may be in use if they had a theatre list at the time. We were not assured that staff were confident in effectively and safely managing deteriorating
patients, that there was a robust system in place which staff could follow and staff had the appropriate training.

**Basingstoke and North Hampshire Hospital**

Staff did not always complete and update 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.

Elective patients attended a nurse-led pre-assessment clinic to ensure they were medically fit for surgery. Risk assessments, dependent on the surgery to be had, were carried out in the nurse-led pre-assessment unit, this included taking the patients’ medical history, physical examination, the screening of blood and urine samples, electrocardiogram tests (ECGs) and MRSA screening. Nurses reviewed results and passed the patient to the anaesthetist for an anaesthetic assessment prior to surgery. If there were medical concerns the nursing team would contact medical staff for further assessments.

Nurses carried out comprehensive risk assessments for patients on admission to the surgical wards. The following risk assessments were completed on admission: falls risk assessment, use bed rails assessments, pressure area risk assessment and a malnutrition universal screening tool (MUST) assessment. We reviewed three sets of patient risk assessments from patients having surgery in the Diagnostic Treatment Centre (DTC) and found the assessments were inconsistent, for example, no Venous thromboembolism (VTE) information seen, bed rail assessments not completed, MUST assessments not completed for all. Individual care plans were not fully completed for two of the patients and not completed at all for the third. Without assessing patient’s risks correctly, appropriate care plans could not be put in place to mitigate these risks and keep patients safe.

Before morning surgery on the ophthalmic day surgery unit, we observed the morning briefing in the anaesthetic room. All members of the surgical team were present and patients were discussed thoroughly including anaesthetic needs and concerns.

Venous thromboembolism (VTE) assessments were recorded in the electronic patient records and there were no paper versions stored in patient notes. Patients were graded as low or high risk. We did not see evidence of actions recorded following the assessment in either the electronic patient record or in the patient’s paper records. We also found no evidence that VTE assessments were being reassessed post-operatively or thereafter in line with the trust’s Venous Thromboembolism (VTE) Risk Assessment and Thromboprophylaxis policy dated 26 January 2018.

We were not assured safety checklists were fully completed. The five steps to safer surgery was used by the hospital, which included the World Health Organisation (WHO) surgical safety checklist. The safety checklist is a recognised tool developed to help prevent the risk of avoidable harm and errors during and after surgery and should include safety-briefing, sign in, time out, sign out and debriefing. The service used three different versions of the modified WHO checklist depending on the surgery taking place. Forms were also colour coded, orange forms were used for general surgery, yellow for orthopaedic surgery and green for local anaesthetic. During our inspection we observed surgery taking place and the WHO checklist in operation. However, this modified WHO checklist did not include the fifth step, debriefing. We were told by theatre staff that trust-wide, the fifth step was not formally carried out and therefore not documented.

After surgery, the hospital used the national early warning scores (NEWS) to monitor patients. This is a tool developed to detect and respond to clinical deterioration in patients. The NEWS
scores six simple physiological parameters, patients respiratory rate, oxygen saturation, temperature, systolic blood pressure, heart rate and level of consciousness. The trust had a deteriorating patient escalation procedure from the patients’ NEWS score. We looked at NEWS scores and were not assured assessments were completed correctly guidance on frequency of observations followed and staff escalated appropriately following changes in patients’ NEWS score. The three NEWS charts we reviewed were incorrectly totalled. This meant there was a risk that staff did not escalate patients appropriately.

We observed the nurse’s handover for patients on the C3 ward and found this was effective. A spreadsheet with an overview of each patients care and treatment was given to members of the nursing team. This included information on the patients’ diagnosis/problem; medical history and social aspects; eating and drinking status; up-coming tests and any patient’s risks to be aware of. There was also a verbal discussion of each patient, where the team could ask more specific questions or handover any additional information.

We observed the doctor’s morning handover for the surgical wards, each patient was discussed in detail. There was online access to patients’ results and scans. A spreadsheet with an overview of each patients care and treatment was given to members of the medical team, this included information on the patients’ diagnosis/problem; past medical history and social aspects; eating and drinking status; up-coming tests and any patient risks to be aware of. There was also a verbal discussion of each patient, where the team could ask more specific questions or handover any additional information. Handover was carried out in an office that was used for many purposes. During the handover we observed other staff coming in and out of the room frequently, as this seemed to be where staff kept their personal belongings which at times distracted staff and the flow of conversations.

We were told by nursing staff working in the Diagnostic Treatment Centre (DTC) they had just introduced a 10am and 4pm huddle. The staff found this a useful way to keep updated on patient and team developments.

Staff we spoke with on C3 the surgical emergency ward told us they had three medical outliers from the following specialities, cardiology, endocrinology and gastroenterology. Staff told us they found it challenging to get daily patient reviews by their specialist consultants, meaning that some patients did not receive daily reviews.

We were told by nursing staff from the DTC that day surgery patients were assessed before discharge and if it was felt unsafe to discharge them i.e. if patients were medically unfit for discharge or there was no one to look after them overnight at home, they were transferred to an inpatient’s ward.

Royal Hampshire County Hospital

Staff did not always complete and update 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.

Elective surgical patients attended a nurse led pre-assessment clinic to ensure they were medically fit for surgery. Risk assessments, dependent on the surgery were carried out in the nurse-led pre-assessment unit, this included medical history, physical examination, the screening of blood and urine samples, ECGs and MRSA screening. Nurses reviewed the results and passed to the anaesthetist for an anaesthetic assessment prior to surgery or back to medical staff if
needed. We saw evidence of this in patients’ notes when high risk patients had been referred back to the medical team for further consultation.

Nurses carried out comprehensive risk assessments for patients on admission to the surgical wards. The following risk assessments were completed on admission: falls risk assessment, use bed rails assessments, pressure area risk assessment and a malnutrition universal screening tool (MUST) assessment. We reviewed patient notes on all the wards we inspected and found that information was missing. For example, on Wainwright ward decisions to use bed rails was recommended there was no documentation to show that discussions had taken place with the patient or family, on Kemp Welsh ward we found that weight and height measurements had not been recorded on the Malnutrition Universal Scoring tool (MUST), and on St Cross ward we found discrepancies in the adding up of the Braden assessments tool score which was used to assess a patient’s risk of developing pressure sores. Without assessing patient’s risks correctly, appropriate care plans could not be put in place to mitigate these risks and keep patients safe.

Venous thromboembolism (VTE) assessments were recorded in the electronic patient records and there were no paper versions stored in patient notes. Patients were graded as low or high risk. We did not see evidence of actions recorded following the assessment in either the electronic patient record or in the patient’s paper records. We also found no evidence that VTE assessments were being reassessed post operatively or thereafter in line with the trust’s Venous Thromboembolism (VTE) Risk Assessment and Thromboprophylaxis Policy dated 26 January 2018.

We were not assured safety checklists were fully completed. The five steps to safer surgery was used by the hospital, which included the World Health Organisation (WHO) surgical safety checklist. The safety checklist is a recognised tool developed to help prevent the risk of avoidable harm and errors during and after surgery and should include safety-briefing, sign in, time out, sign out and debriefing. The service used three different versions of the modified WHO checklist depending on the surgery taking place. Forms were also coloured coded, orange forms were used for general surgery, yellow for orthopaedic surgery and green for local anaesthetic. During our inspection we observed surgery taking place and the WHO checklist in operation. However, this modified WHO checklist did not include the fifth step, debriefing. We were told by theatre staff that trust-wide, the fifth step was not formally carried out and therefore not documented.

After surgery, the hospital used the national early warning scores (NEWS) to monitor patients. This is a tool developed to detect and respond to clinical deterioration in patients. The NEWS scores six simple physiological parameters, patients respiratory rate, oxygen saturation, temperature, systolic blood pressure, heart rate and level of consciousness. The trust had a deteriorating patient escalation procedure from the patients’ NEWS score. We looked at NEWS scores and were not assured assessments were completed correctly, guidance on frequency of observations followed and staff escalated appropriately following changes in patients’ NEWS score. We looked at five patient’s records for NEWS scores on Bartlett ward. In these records we could not find any paper records of NEWS scores. We were therefore not assured they were taking place.

**Nurse staffing**

The trust has reported their nursing staffing numbers below as at February 2018, showing a staffing rate of 87.5%.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hampshire Hospitals NHS Foundation Trust</td>
<td>at February 2018</td>
<td>rate (%)</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>473.9</td>
<td>414.9</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

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

Vacancy rates

From March 2017 to February 2018, the trust reported a vacancy rate of 10.8% in surgery, compared to the 8% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 10.5%
- Royal Hampshire County Hospital: 11.0%
- Andover War Memorial Hospital: 8.9% (theatres)
- Multi-site: 13.1%

Ward D4 had the highest annual vacancy rate at Basingstoke and North Hampshire Hospital with 37.2%, followed by DTC Theatres with 23.0%. Wainwright ward had the highest annual vacancy rate at Royal Hampshire County Hospital with 33.3%.

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

Turnover rates

From March 2017 to February 2018, the trust reported a turnover rate of 11.0% in surgery, compared to the 12% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 10.5%
- Royal Hampshire County Hospital: 12.3%
- Andover War Memorial Hospital: 0% (theatres)

The anaesthetic unit office had the highest annual turnover rate of 31.6% at Basingstoke and North Hampshire Hospital, followed by ward D3 with 28.9%. The orthopaedic fracture clinic had the highest annual turnover rate at Royal Hampshire County Hospital with 41.2%, followed by St Cross ward with 26.6%.

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

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 4.3% in surgery, compared to a 3.5% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 4.6%
- Royal Hampshire County Hospital: 3.6%
- Andover War Memorial Hospital: 13.1% (theatres)

Diagnosis and treatment centre services had the highest annual sickness rate at Basingstoke and North Hampshire Hospital with 12.5%, followed by ward D4 with 12.0% and ward D3 with 11.3%. The orthopaedic fracture clinic had the highest annual sickness rate at Royal Hampshire County Hospital with 9.9%, followed by Bartlett ward with 5.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and agency staff usage

Please note that we are unable to calculate bank and agency usage as a proportion of the total number of shifts available including those covered by permanent staff since the trust was unable to provide the total number of available shifts.

The below table shows total shifts filled by bank/agency qualified nursing staff and shifts left unfilled from March 2017 to February 2018 in surgery at Hampshire Hospitals NHS Foundation Trust by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and North Hampshire Hospital</td>
<td>4,306</td>
<td>1,042</td>
<td>1,485</td>
</tr>
<tr>
<td>Royal Hampshire County Hospital</td>
<td>2,527</td>
<td>250</td>
<td>1,082</td>
</tr>
<tr>
<td>Andover War Memorial Hospital</td>
<td>4</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Multi-site</td>
<td>68</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>6,905</td>
<td>1,292</td>
<td>2,567</td>
</tr>
</tbody>
</table>

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

Theatre staffing

Theatre shifts and staff allocations were based on the guidance from the Association of Perioperative Practice (AfPP).

Andover War Memorial Hospital

The day surgery unit had core staff who had worked there for several years and had a very low turnover of staff. There was a mixture of full and part time staff. We were told that at the time of our inspection, July 2018, there were no current vacancies. The staff sickness rate in the unit was higher than usual but staff said that this was not affecting patients’ care as their own staff would pick up extra shifts to provide continuity in care.

The unit was staffed with a multi-flexible team of registered nurses, theatre practitioners and healthcare assistants, who could work in all areas of the department.

Basingstoke and North Hampshire Hospital

We reviewed safer staffing information for February to May 2018 that was presented to the trust board. The records showed that Basingstoke and North Hampshire Hospital was not always meeting the target for average fill rate for registered nurses and healthcare assistants on the surgical wards and the Diagnostic Treatment Centre (DTC).

In the February 2018 safer staffing report, two wards, D3 and D4, did not meet the 90% standard for registered nursing (RN) staffing day compliance, 86% & 77% respectively. Three wards, C2, D3 and D4, did not meet the 90% compliance for RN staffing on nights, 89%, 81% & 75% respectively. C3 and D1 did not achieve the 90% standard for Healthcare assistants (HCAs) day staffing, 87% & 82%. The staffing levels on D3 and D4 ward meant that one registered nurse looked after more than eight patients. The NICE staffing guidelines recommends a safe nurse staffing ratio of 1:8.
In the March 2018 safer staffing report, two wards, D3 and D4, did not meet the 90% standard for registered nursing (RN) staffing day compliance, 85% & 74% respectively. Two wards, C2 and D4, did not meet the 90% compliance for RN staffing on nights, 89% & 77%. C3 and D1 did not achieve the 90% standard for healthcare assistants (HCAs) day staffing, 86% & 89% respectively. The staffing levels on D3 and D4 ward meant that one registered nurse looked after more than eight patients. The NICE staffing guidelines recommends a safe nurse staffing ratio of 1:8.

In the April 2018 safer staffing report, two wards, D3 and D4, did not meet the 90% standard for registered nursing (RN) staffing day compliance, 87% & 75% respectively. One wards, D4, did not meet the 90% compliance for RN staffing on nights, 75%. C3 and D1 did not achieve the 90% standard for healthcare assistants (HCAs) night staffing, 89% & 87% respectively.

In the May 2018 safer staffing report, three wards, D1, D3 and D4, did not meet the 90% standard for registered nursing (RN) staffing day time compliance, 84%, 87%, & 71% respectively. Two wards, C2 and D4, did not meet the 90% compliance for RN staffing on nights 88% & 72% respectively. C3 did not achieve the 90% standard for Healthcare assistants (HCAs) day staffing, 83% and D1 did not achieve the 90% standard for healthcare assistants (HCAs) night staffing, 80%.

All four safer staffing reports noted that some of the RNs staffing were bank and/or agency staff and therefore, whilst the percentage average fill rate was met the skills of staff or their capacity, training and competency might not have been to the required trust standards.

During our inspection we spoke with nursing staff on the wards and were told of the current staffing vacancies. Whilst it is known that there is a national shortage in the recruitment of nurses, we were also told that staffing vacancies were due to a lack of career progression and the workload expected of them. Staff told us they were over reliant on bank and agency staff.

Royal Hampshire County Hospital

We reviewed safer staffing information for February to May 2018 that was presented to the trust board. The records showed that Royal Hampshire Country Hospital was not always meeting the target for average fill rate for registered nurses and Healthcare assistants on the surgical wards and the Short Stay Surgical Unit (SSSU).

In the February 2018 safer staffing report, two wards, Bartlett and St Cross, did not meet the 90% standard for registered nursing (RN) staffing day compliance, 87% & 86% respectively. Kemp Welch ward and the treatment centre did not achieve the 90% standard for healthcare assistants (HCAs) day staffing 70% & 82% respectively. The staffing levels on Bartlett ward meant that one registered nurse looked after more than eight patients. The NICE staffing guidelines recommends a safe nurse staffing ratio of 1:8.

In the March 2018 safer staffing report, two wards, Bartlett and St Cross, did not meet the 90% standard for RN staffing day compliance, both wards at 87%. Kemp Welch ward did not achieve the 90% standard for HCA day staffing, 72%. The staffing levels on Bartlett and St Cross wards meant that one registered nurse looked after more than eight patients. The NICE staffing guidelines recommends a safe nurse staffing ratio of 1:8.

In the April 2018 safer staffing report, one ward, Bartlett did not meet the 90% standard for RN staffing day compliance, 77%. Kemp Welch and St Cross wards did not achieve the 90% standard
for HCA day staffing, 73% & 89%. St Cross ward did not achieve the 90% standard for HCA night staffing, 75%. The staffing levels on Bartlett ward meant that one registered nurse looked after more than eight patients. The NICE staffing guidelines recommends a safe nurse staffing ratio of 1:8.

In the May 2018 safer staffing report, two wards, Bartlett and St Cross did not meet the 90% standard for RN staffing day compliance, 80% & 87% respectively. Bartlett ward did not meet the 90% standard for RN night staffing, 71%. Kemp Welch and St Cross wards did not achieve the 90% standard for HCA day staffing, 83% & 71%. St Cross ward did not achieve the 90% standard for HCA night staffing, 40%. The staffing levels on Bartlett ward meant that one registered nurse looked after more than eight patients. The NICE staffing guidelines recommends a safe nurse staffing ratio of 1:8.

All four safer staffing reports noted that some of the RN staffing was bank and/or agency staff and therefore, whilst the percentage average fill rate was met the skills of staff or their capacity, training and competency might not have been to the required trust standards.

During our inspection we spoke with nursing staff on the wards and in theatres about staffing levels. We were told by ward staff that they mitigated against registered nurse shortages by increasing the number of healthcare assistants on the ward. At the time of our inspection feedback from staff told us that due to staff shortages the Band 7 was managing both Kemp Welch and Wainwright wards and these wards worked as one unit sharing staff and helping each other out. During our inspection we saw the same staff on both wards at different times. Addition information supplied by the trust after the inspection informed us that a change in senior team structure was due to occur. Currently a Band 6 nurse managed the Wainwright ward with support from the clinical matron and the Band 7 nurse from Kemp Welch ward. It had been decided that due to increased complexity of patients on Wainwright ward, the ward was to be managed by its own band 7 nurse with the clinical matron overseeing both wards.

We were told by nursing staff that due to the staffing shortages on Wainwright ward a patient’s medication had been changed so that it did not require two registered nurses (RNs) to administer. We were told there were only two RNs on a shift at a time and it was not easy for them to administer drugs together. Changing medication was not for the benefit of the patient but more a practical solution for staff.

We were told by nursing staff that Bartlett ward ran on bare minimum staff and were reliant on bank staff. We were told that bank staff, if they had the choice would not opt to work on Bartlett ward and would instead work on a less demanding ward.

During our inspection we spoke with nursing staff on the wards and in theatres and were told of the current staffing vacancies. Staff told us they were over reliant on bank and agency staff.

**Medical staffing**

**Andover War Memorial Hospital**

There were no surgical consultants and registrars based at the Andover War Memorial Hospital or on the day surgery ward. Medical staff from the other two sites, Basingstoke and North Hampshire
Hospital and Royal Hampshire County Hospital went to the Andover site to carry out minor surgery, other investigatory and endoscopy procedures.

**Basingstoke and North Hampshire Hospital / Royal Hampshire County Hospital**

Surgical services were consultant delivered and led. We saw medical staff carry out ward rounds. Many of the surgeons tended to work across both sites but this was not the case for all. The surgical specialties were made up of consultants, specialty registrars, senior house doctors and foundation doctors.

Anaesthetic consultants and teams worked across the different sites.

The trust has reported their medical staffing numbers below as at February 2018.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at February 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire Hospitals NHS Foundation Trust</td>
<td>287.8</td>
<td>268.4</td>
<td>93.3%</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From March 2017 to February 2018, the trust reported a vacancy rate of 7.4% in surgery, compared to the 8% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 9.4%
- Royal Hampshire County Hospital: 7.9%
- Multi-site: 1.0%

The orthodontic department had the highest annual vacancy rate at Basingstoke and North Hampshire Hospital and at Royal Hampshire County Hospital with 52.2% and 27.1% respectively. Multi-site had over-established levels for general surgery junior medical staff (2.3%) and general surgery medical staff (3.2%).

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

**Turnover rates**

From March 2017 to February 2018, the trust reported a turnover rate of 38.1% in surgery, compared to the 12% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 44.5%
- Royal Hampshire County Hospital: 30.7%

Across the two sites, anaesthetic junior medical staff at Royal Hampshire County Hospital had the highest annual turnover rate with 78.6%, followed by ENT and general surgery at Basingstoke and North Hampshire Hospital with 67.0% and 63.8% respectively.

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

**Sickness rates**
From March 2017 to February 2018, the trust reported a sickness rate of 0.9% in surgery, compared to a 3.5% provisional trust target. A site breakdown can be viewed below:

- Basingstoke and North Hampshire Hospital: 1.1%
- Royal Hampshire County Hospital: 0.6%

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

**Bank and locum staff usage**

Please note that we are unable to calculate bank and locum usage as a proportion of the total number of shifts available including those covered by permanent staff because the trust was unable to provide the total number of available shifts.

The below table shows total shifts filled by bank medical staff from March 2017 to February 2018 in surgery at Hampshire Hospitals NHS Foundation Trust by site; there were no reported shifts filled by locum medical staff and no data for how many shifts were not filled:

<table>
<thead>
<tr>
<th>Site</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and North Hampshire Hospital</td>
<td>41</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>Royal Hampshire County Hospital</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Multi-site</td>
<td>42</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84</strong></td>
<td><strong>23</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

The trust stated that the anaesthetic ward in surgery at Basingstoke and North Hampshire Hospital had the highest bank usage with 0.25%. The vacancy rate was 20.3%, although the trust did not state what this is mainly attributed to.

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

**Staffing skill mix**

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

**Staffing skill mix for the whole time equivalent staff working at Hampshire Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
Records

Andover War Memorial Hospital

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The trust used two different record keeping systems with some data stored electronically and other data stored in the traditional paper-based record. Patients records were requested and available up to 48 hours prior to surgery.

No patient notes were kept at the day surgery unit. Notes used whilst patients were present on the unit were keep on the desk at the nurses’ station in the recovery area. At the end of surgery, they were sent to the Royal Hampshire Country Hospital for coding and storage. We observed nursing staff completing patients’ notes with all the relevant information before these notes were deemed ready for collection.

The day surgery unit used a patient management system that tracked the patient during their visit to the unit. During our inspection we observed nurses using this system.

Basingstoke and North Hampshire Hospital

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.

The trust used two different record keeping systems with some data stored electronically and other data stored in the traditional paper-based record. Data was not always on the same system for each patient i.e. sometimes patients weight and height were recorded on the electronic patient record and for others it was in their paper notes. This non-standardisation could lead to confusion were to look for information or information could get missed all together.

The Diagnostic Treatment Centre (DTC) used a patient management system that tracked the patient during their visit to the unit from arrival to discharge. During our inspection we observed nurses using this system and it meant that staff knew where patients were in their journey at all times.

During the inspection we reviewed 10 sets of notes from across the wards we visited at Basingstoke and North Hampshire hospital.

We found that patients records varied in quality. Some records were fully completed covering all aspect of the patient’s care from preoperative assessment through surgery and up to discharge. Care plans were completed, full risk assessments, medicines reconciliations and discharge letters. Other records were missing significant detail. For example, records we reviewed on C3 ward were missing admission data, such as was the patient ID in place and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status, entries were not signed or name printed as per instructions.

We found risk assessments were not completed correctly. On C3 ward we saw patient records whose NEWS scores were added up incorrectly. The score given meant that the patient needed closer monitoring, however, this was not implemented. NEWS scores recorded incorrectly could impact on patients’ care and safety, as escalation processes would not be followed in a timely
way. We reviewed NEWS audit data from the safe staffing reports for February to March 2018 for the surgery wards. Audit results show that only C2 and C4 wards reached the trust's target of 90%. Audit results for the other wards, C3, D1, D3, D4 and the Diagnostic Treatment Centre (DTC) showed audit data ranged from 9.5% to 86%.

Nursing records of care did not always give details of the care provided. We found gaps in nursing care records at the Diagnostic Treatment Centre (DTC). Individual care plans were partially completed and medication records were not completed fully.

Incomplete records put patients at risk and showed that staff were not following the Records Management Code of Practice for Health and Social Care 2016, as well as guidance from professional bodies.

We requested from the trust, information on the surgery wards patient’s note audits and any resulting action plans. We did not receive this information therefore we were unsure if auditing of patient records was carried out.

The storage of notes was not consistent across all wards that we inspected. Some wards kept notes in lockable trolleys, others behind the nurses' stations, while others were in open trolleys by the nurse’s station so staff could access patient notes easily. This did not protect patients' records as these could be accessed by unauthorised people. The pre-assessment unit kept patients’ record in the senior sister’s office. This room was not locked during the day and at times the door was open. Patients' records were kept in unlockable filing cabinets inside this room. The office was on the main corridor through the unit and was also the access route to and from the discharge lounge.

Royal Hampshire County Hospital

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.

The trust used two different record keeping systems with some data stored electronically and other data stored in the traditional paper-based record. Data was not always on the same system for each patient i.e. sometimes patients' weight and height were recorded on the electronic patient record and for others it was in their paper notes. This non-standardisation could lead to confusion were to look for information or information could get missed all together.

During the inspection we reviewed 20 sets of notes from across the wards we visited at the Royal Hampshire County hospital.

We found that patient’s records varied in quality. Some records were fully completed covering all aspect of patient care from preoperative assessment through surgery and up to discharge. Care plans were completed, full risk assessments, medicines reconciliations and discharge letters. Other records were missing significant detail. For example, records we reviewed on St Cross ward had no Abbey pain score completed. We found risk assessments not completed correctly. On St Cross ward the Braden pressure ulcer risk assessments were added up incorrectly. This meant the patient might not be receiving the necessary level of care or was given the right equipment to make sure pressure ulcers were manged correctly. On Kemp Welch ward we saw no weight and height measures on the malnutrition universal screening tool (MUST) assessment.

We reviewed NEWS audit data from the safe staffing reports for February to March 2018 for the surgery wards. Audit results show that only Wainwright ward reached the trust's target of 90% for both months, 100% for both months. Kemp Welch ward, St Cross ward and the surgical short stay...
unit reached the trust’s target in February 100%. 100% & 95% respectively. However, they did not reach the target in March with audit results of 88%, 74% and no results reported respectively. Bartlett ward did not reach the 90% target for either month with 83% and 85% respectively.

Nursing records of care did not always give detail of the care provided. We saw patients notes on St Cross ward for a patient living with dementia that was missing the correct Mental Capacity Act documentation. On Kemp Welch ward although the risk assessment indicated that a patient was a high risk of falling the care plan did not reflect this.

Incomplete notes put patients at risk and showed that staff were not following the Records Management Code of Practice for Health and Social Care 2016, as well as guidance from professional bodies.

We requested from the trust, information on the surgery wards patient’s note audits and any resulting action plans. We did not receive this information therefore we were unsure if auditing of patient records was carried out.

The storage of notes was not consistent across all wards that we inspected. Some wards kept notes in lockable trolleys, others behind the nurses’ stations, while others were in open trolleys by the nurse’s station. This did not protect patients records as these could be accessed by unauthorised people.

Medicines

Andover War Memorial Hospital

The service did not have robust processes to manage medicines safely.

Medicines in the day surgery unit were not stored appropriately.

Medicines were stored in a locked room. Medicines were not managed safely and there was no systematic checking of expiry dates or of stock levels. When we checked we found expired drugs and intravenous fluids, for example, hydrocortisone dated 03/2018, bupivacaine hydrochloric dated 05/2018, Lidocaine injection dated 04/18. There were two red open boxes that contained blister packs of antibiotics and analgesics. The lack of process for checking medicines put patients at risk of receiving expired medicines and intravenous fluids.

We were told by nursing staff the assortment of blister strips had accumulated as they were borrowed from other areas in the hospital or excess to the TTO (to take out medications) requirements of patients. We were told that these drugs were dispensed to patients if the patient was normally on them but had forgotten to bring a supply to the hospital with them. These medicines were loose and not stored in their boxes with their information leaflets and had not been checked by a pharmacist. We were told by a senior nurse that this system had been in place many years. Staff were not aware that these medicines were not managed safely as per medicines guidelines.

In the medicines room there were emergency first aid boxes for treatment such as hypoglycaemia (low blood sugar) or anaphylaxis (treatment for allergic reactions). These boxes were not regularly checked and there was no process in place to do so. Where boxes had a content list attached to them, the box did not contain what was on the list. Needles in the Anaphylaxis box had expired in 2016.

Medicines were not stored separately from other personal items for example, personal bags belonging to staff, a jar of coffee, boxes of stationary unrelated to medicine management. This did not follow the trust’s medicine management and optimisation policy which states that ‘no other
substances or articles may be stored in these cupboards, which must be reserved strictly for the storage of medicine’. This meant that other staff could access the cupboard and the trust was failing to manage medicines storage safely. As well as personal items there were other items stored directly on the floor including bottles of fluid flush, blue medicines bins and iodine.

The medicines room felt hot and there was no monitoring of the room temperature. This meant there was no evidence that the room was maintained below 25 degrees Celsius, as required for medicine storage.

We checked the medicine storage refrigerator and found that they were not checked consistently. There were missing daily checks and the temperatures were not checked in the evening or at weekends. The sheet used to record the temperature said that three checks a day should be recorded. Minimum and maximum temperatures were not recorded which meant it could not be ensured that temperatures did not go above or below recommended storage temperatures which would impact on the medicines efficacy.

We checked the controlled drug cupboard and documentation and found all drugs to be in date and all documentation correct except for one entry. There had been a discrepancy of the number of ampoules recorded. The record had been changed and staff had not followed the trust process of signing the entry. All other adjustments had been correctly recorded.

There was no pharmacy onsite at the Andover hospital. They were supported by the pharmacy department by the Royal Hampshire County hospital on the Winchester site. We were told by staff in the day surgery unit it was the Winchester pharmacy team’s responsibility to monitor and check medicines. However, the trust’s Medicine optimisation policy states it was the nursing staff’s responsibility to check medicines. The nursing staff in the day surgery unit told us they had not been visited by any member of the pharmacy team for at least four months due to staff shortages. During the inspection we were told by the pharmacy team there was a pharmacy rota but due to staff shortages they sent resources to high risk areas. The day surgery unit was not considered high risk. As there had been no pharmacy support and nursing staff did not know it was their responsibility there had been no checking or monitoring of medications for the previous four months. It was unclear to us what the level of pharmacy support and checking of medication had been had been prior to this. Nursing staff told us they currently ordered drugs online and they would be delivered to the unit by hospital transport. It usually took 48 hours to receive the drugs ordered. This means there was no pharmacy oversight in the management of medicines, including patients’ drug reconciliation. After highlighting the issues that we found during our inspection the nurse in charge removed and disposed of the red open boxes containing the antibiotics and analgesics. They also escalated our concerns of lack of pharmacy support to the clinical matron of the day surgery unit, who was based at the Winchester site.

We followed up on this at our unannounced inspection and found staff had taken some action and we found no expired drugs. However, we found two bottles of videne antiseptic solution with an expiry date of 04/18. The room had been tidied but there were still items on the floor and inappropriate items being stored in the room. Nursing staff had implemented an alphabetical storage of medicines which made drugs easier to check and find. We checked the hypoglycaemia boxes and found that weekly checks were being carried out but the content still did not match the content list inside the box.

We spoke to nursing staff who told us there was still no pharmacy presence in the unit but the nursing team has started to carry out twice weekly drug checks. However, they said the pharmacy checklist made no sense to them so they were not using it. They had adopted the system of checking the expiry dates and counting how much stock they had of each item. They would
dispose of expired medicines, if they needed more stock they would order it online. We asked if they documented the checks they made or had a stock list, they told us they did not.

Although improvements had been made we were still not assured there was a robust system in place and we still had concerns with the lack of pharmacy support.

Basingstoke and North Hampshire Hospital

The service did not always follow best practice when prescribing, giving, recording and storing medicines.

Medicines were stored securely in the surgical wards, theatres and departments we inspected, with medicines in lockable rooms or lockable drug trolleys. However, on some of the wards we inspected, patients own medicines were stored in a block of lockers rather than in a locker by the patient’s bed. This meant there could be a risk of the wrong patient receiving the wrong medication.

Medicines were not checked and manged safely. When we checked drugs throughout the surgical services we found expired drugs, for example expired clexane 02/2018 in theatre 3, ceftazidime 04/18 and suxamethonium chloride 02/18 in the diagnostic treatment centre (DTC). We also found medication blister packs not kept in their boxes without their information leaflets, in the medicine trolley in C2 ward.

Throughout the hospital medicine room temperatures were not monitored. This meant there was no evidence that the room was maintained below 25 degrees Celsius, in line with manufacturer’s guidance for medicines storage.

We checked medicines storage refrigerators on all surgical wards and areas we inspected and found that temperatures were not checked consistently. There were missing daily checks, especially at the weekends. When we spoke to staff working on the wards, the daily checks seemed to be the responsibility of the housekeeper and if they were unavailable or did not work weekends, the fridge temperatures were not checked. Only the current fridge temperature was recorded not the minimum and maximum. This meant it could not be ensured that temperatures did not go above or below recommended storage temperatures. If this happened it could impact on the medicines efficacy. Throughout the hospital, fridge temperatures records were not audited.

We checked controlled drugs (CDs) stored in the surgical wards, theatres and departments we inspected. We found that CDs were stored correctly, in date and required documentation recorded according to legal requirements.

On the surgical wards and departments, we were shown specific drugs boxes for situations such as hypoglycaemia or anaphylaxis. When we checked these boxes, they contained the correct items and medication according to the content list, with medicines being in date.

We found that TTO (to take out), medicines given to patient on discharge from hospital, supplied from ward TTO cupboards did not have patient specific directions on them. We found a box of assorted medication, for example, Amitriptyline, Amoxicillin & Naproxen were stored in an open cardboard box. These drugs had been borrowed from other wards or had been surplus to TTO requirement and had been kept to save staff going through pharmacy for certain medication. These medications were not stored in their boxes with their information leaflets and had not been checked by a pharmacist.

When we spoke with staff on the surgical wards and other surgical areas we were told that the clinical pharmacy service was sporadic, with some wards not having regular pharmacy support.
During this inspection we were told by ward nursing staff on C4 ward that the pharmacy technician had telephoned to say they were unable to cover the ward that day. 

There were no mandatory medicine updates for staff. However, new staff were supervised and competency assessed in the safe administration of medicines. Patients on high risk medication or living with chronic conditions were prioritised by the pharmacy team and wards could access specialist nurses for additional support.

We were told by nursing staff that each ward had a medicines management link nurse. This group of nurses met every two months to discuss medicine safety issues and incident reporting themes. We saw a folder on C4 ward where notes of these meetings were kept so other staff could read them if they wished.

The hospital had an electronic prescribing system but we saw instances where patient information had not been recorded, this included patients’ body weights, although sometimes this information was found in the patient’s paper records.

Royal Hampshire County Hospital

The service did not always follow best practice when prescribing, giving, recording and storing medicines.

Medicines were stored securely in the surgical wards, theatres and departments we inspected, with medicine in lockable rooms or lockable drug trolleys. However, patients own medicines on some of the wards we visited, were stored in a block of lockers rather than in a locker by the patient’s bed meaning there could be a risk of the wrong patient receiving the wrong medication.

When we checked drugs throughout the surgical services we found drugs and drug checking records in date and completed correctly. When we spoke with staff on the surgical wards and other surgical areas we were told that the clinical pharmacy service was sporadic, with some wards not having regular pharmacy support. This meant most wards had taken to checking and monitoring their own medicine supplies. With the lack of pharmacy support, it had become unclear to staff working in the surgery service what their role and responsibility was in the management of medicines and the responsibility of the pharmacy team. The nursing staff on Wainwright ward said they had been no clinical pharmacy service for six to eight months. They were having problems getting unwanted CDs collected. This meant their CD cupboard was getting full, which could cause confusion when looking for the correct medication.

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We were told by nursing staff on Kemp Welch ward that there was no ventilation in their treatment room, the room got hot which in turn made the fridge overheat. They had added this to
their risk register but had not been addressed. As dates were not added to the risk register we were unsure how long it had been on the risk register for.

We checked controlled drugs (CDs) stored in the surgical wards, theatres and departments we inspected. We found that CDs were stored correctly, in date and required documentation recorded according to legal requirements.

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The hospital had an electronic prescribing system but we saw instances where patient information had not been recorded, this included patients’ body weights, although sometimes this information was found in the patient’s paper records.

Incidents

Trust wide

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and gave patients honest information and suitable support. However, incidents were not always investigated in a timely way.

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 had the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2017 to March 2018, the trust reported one serious incident classified as a never event for surgery, which was for wrong site surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England where the serious incident occurred between April 2017 and March 2018.
Of these, the most common types of serious incident reported were:

- Slips/trips/falls meeting SI criteria with six (38% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with three (19% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (13% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (6% of total incidents).
- VTE meeting SI criteria with one (6% of total incidents).
- All other categories with three (19% of total incidents).

Basingstoke and North Hampshire Hospital had eight (50%) serious incidents, including the never event mentioned in the section above; five (62.5%) were for slips, trips and falls. Royal Hampshire County Hospital had five serious incidents.

(Source: Strategic Executive Information System (STEIS))

Andover War Memorial Hospital

Staff we spoke with in the day surgery 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.

The trust supplied us with incident data for the surgery services at Andover War Memorial Hospital from June 2017 to May 2018. During this period there were 39 near misses and 29 incidents resulting in no harm. There were 10 incidents that resulted in low harm (this meant minimal harm that required extra observation or minor treatment) and no incidents that resulted in moderate harm (this meant short term harm that required further treatment or procedure).

Staff told us feedback from incidents was discussed during daily staff catch ups and in handover sessions. However, we were not assured how information was disseminated from senior staff members to the team in the day surgery unit. 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.

Currently duty of candour was not part of the trust’s mandatory training. None of the staff we spoke with on this inspection had been involved in Duty of Candour issues and we were told by the trust there had been no incidents at the day surgery unit which had required a formal Duty of Candour process.
Basingstoke and North Hampshire Hospital

Staff we spoke with in the day surgery 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 were able to give us examples of when they had needed to report an incident.

The service used many ways to ensure staff received feedback about incidents. Information was emailed to staff and spoken about in meetings, handovers and daily huddles. The Diagnostic Treatment Centre staff had a good model for reviewing incidents and complaints, with each area having a monthly complaints meeting. They discussed training requirements for reporting incidents, reviewed current incidents, any shared learning needed and any changes in practices that might be required. Any serious issues or reoccurring themes would be reported up to the Theatre Management Group meeting which in turn fed into the Divisional Surgical Governance.

Senior medical staff explained how surgical processes had changed since the NEVER event of wrong side surgery had occurred.

The trust supplied us with incident data for the surgery services at Basingstoke and North Hampshire Hospital from Jun 2017 to May 2018. During this period there were 2260 near misses and 1620 incidents resulting in no harm. There were 618 incidents that resulted in low harm (this means minimal harm that required extra observation or minor treatment) and 13 incidents that resulted in moderate harm (this meant short term harm that required further treatment or procedure).

From data supplied by the trust from June 2017 to May 2018, the following areas reported the most amount of surgery incidents, D3 ward with 8% of total incidents, D4 with 7% of total incidents, main theatres with 5% of incidents and C3 and D1 wards with 4% of total incidents.

We saw evidence that mortality and morbidity meetings were held. 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. Each surgery speciality held their own meeting. There was no standardisation format for these meetings, with each group setting their own agendas. The Royal College of Surgeons recommend a standardised way of presenting cases, as this can improve the quality of the presentations and help identify learning points more easily.

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.

Currently duty of candour was not part of the trust’s mandatory training. However, the majority of staff we spoke with had awareness of and were able to explain the duty of candour.

Royal Hampshire County Hospital

Staff we spoke with in the day surgery 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 were able to give us examples of when they had needed to report an incident.

The service used many ways to ensure staff received feedback about incidents. Information was emailed to staff and spoken about in meetings, handovers and daily huddles. The theatre team
had the latest five incidents that had occurred in the department on a noticeboard and the learning from them was shared. The matron from Kemp Welch ward told us additional training had been organised for the team after a fall incident had occurred on the ward.

Senior medical staff explained how surgical processes had changed since the NEVER event of wrong side surgery had occurred.

The trust supplied us with incident data for the surgery services at Royal Hampshire County Hospital from June 2017 to May 2018. During this period there were 1254 near misses and 843 incidents resulting in no harm. There were 391 incidents that resulted in low harm (this means minimal harm that required extra observation or minor treatment) and 11 incidents that resulted in moderate harm (this meant short term harm that required further treatment or procedure).

From data supplied by the trust from June 2017 to May 2018, the following areas reported the most amount of surgery incidents, Bartlett ward with 8% of total incidents and Kemp Welch ward with 5% of total incidents.

We saw evidence that mortality and morbidity meetings were held. 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. Each surgery speciality held their own meeting. There was no standardisation format for these meetings, with each group setting their own agendas and style. The Royal College of Surgeons recommend a standardised way of presenting cases, as this can improve the quality of the presentations and help identify learning points more easily.

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Currently duty of candour was not part of the trust’s mandatory training. However, the majority of staff we spoke with had awareness of and were able to explain the duty of candour. We were given an example by the clinical matron on Kemp Welch ward when the duty of candour process had been followed and initiated.

### Safety thermometer

#### Trust wide

The service used safety monitoring results well. Staff collected safety information and shared it with staff but not always with the patients and visitors. Managers used this information to improve the service.

The Safety Thermometer was 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. The safety thermometer focuses on four most commonly occurring harms in healthcare: pressure ulcers, falls, urinary tract infection (UTI) in patients with a catheter and venous thromboembolism (VTE).

Data collection took place one day each month, a suggested date for data collection was given
but wards could change this. Data must be submitted within 10 days of suggested data collection date.

Data was collected by the wards and this helped the surgical services to understand the burden of harm in each area, monitor their performance over time and put in measures to improve patients care. Data was reviewed at the surgery divisional board meeting and trust patient safety meetings.

The May 2018 safer staffing report to the board of directors included a trust wide analysis of safety thermometer results.

Data from the Patient Safety Thermometer showed that the trust reported 16 new pressure ulcers, 11 falls with harm and 12 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Hampshire Hospitals NHS Foundation Trust

![Graphs showing prevalence rates](image)

(Source: NHS Digital)

Andover War Memorial Hospital

The day surgery unit did not display safety thermometer data.

Basingstoke and North Hampshire Hospital

The safety thermometer was not consistently displayed in all wards.
Royal Hampshire County Hospital
The safety thermometer was consistently displayed outside all the wards we visited.

Is the service effective?

Evidence-based care and treatment

Andover War Memorial Hospital
The service did not always ensure that care and treatment was consistently based on national guidance and that staff followed this guidance.

Staff provided care and treatment to patients based on national guideline such as the National Institute for Health and Care Excellence (NICE) guidelines.

Preoperative assessments prior to day surgery and endoscopy procedures were carried out and advice given such as if patients needed to be fasted.

We reviewed standard operating procedures (SOPs) written especially for the Andover War Memorial Hospital (AWMH) two theatres and found the majority of surgical SOPs were in date.

We were told by staff that local audits were carried out, however we found little documented evidence to support this. In addition, when we checked the surgery division monthly summary reports supplied to us by the trust, AWMH was not included in the data.

Basingstoke and North Hampshire Hospital / Royal Hampshire County Hospital
Staff had access to national guidance but the service did not always ensure that care and treatment was consistently based on national guidance and that staff followed this guidance.

In theatres we observed evidence that the theatre team was not following the World Health Organisation (WHO) Surgical Safety Checklist and ‘five steps to safety’ surgical approach. An audit of surgical notes against set standards carried out by the trust in the last 12 months, showed that 6% of the 150 patient notes looked at, were compliant with all five elements of the WHO checklist. Where the elements one to four showed good compliance ≥80%, the fifth element, debriefing, was at 22% compliance. We were told by theatre staff that trust-wide that debriefing was not formally carried out.

There was a lack of evidence that staff consistently carried out venous thromboembolism (VTE) assessments and prescribed appropriate prophylaxis, in line with NICE quality standard QS3.

Surgical and trauma services delivered care and treatment broadly in line with evidence based care and professional guidance, including from the Royal College of Surgeons, The Royal College of Anaesthetists, and the National Institute for Health and Care Excellence (NICE) guidelines.

Preoperative assessments nurses used evidence-based protocols to assess patients’ fitness for surgery.

At BNHH and RHCH the service offered an enhanced recovery programme for patients needing joint replacements or revisions. This included asking patients to attend ‘joint school’ in advance of the procedure, to prepare patients for their surgery and what to expect after the operation. Enhanced recovery programmes have been shown by the NHS Institute for Innovation and Improvement, to help patients recover more quickly after surgery.
The service participated in relevant national audits to measure the effectiveness of the care and treatment provided. This included the National Bowel Cancer Audit (2017) and the National Hip Fracture audit. The service also participated in the Commissioning for Quality and Innovation (CQUIN) national goals audit of the WHO checklist. In theatres we were told about the stop before you block and the Coventry cement curfew implant check audits. Also, the clinical care Audit R program which looked at clinical measures such as compliance with NEWS, fall assessments and nutrition needs across the service. Audit findings were used to improve practices and the quality of patient care received in the unit.

**Nutrition and hydration**

**Andover War Memorial Hospital**

Staff gave patients enough food and drink to meet their needs and improve their health.

Patients admitted for day surgery were provided with snacks and light meals if required following their operations. Staff ensured they had received food and fluids prior to discharge. If patients needed to arrive at the unit fasted prior to their surgery, this information was provided to the patient during the booking process. On arrival to the unit on the day of their surgery, it would be confirmed with patients that they had fasted.

Patients undergoing orthopaedic and cataracts procedures were all admitted at the same time and consulted by the consultants before they started their list. This was not in line with good practice guidance (British Association of Day Surgery 2012) which recommends that there should be staggered admissions to limit fasting and waiting times.

**Basingstoke and North Hampshire Hospital / Royal Hampshire County Hospital**

Staff gave patients enough food and drink to meet their needs and improve their health.

The trust self-assessments reported that they were fully compliant with the Nutrition Alliance, 10 key characteristics of good nutritional care and the British Diabetic Association guidance on menu planning, however, since the trust went to a patient electronic meal ordering system there was no ability to code dishes on the menu. The trust told us they were working on a way to resolve this.

Staff assessed patients' nutritional status on admission with NICE guidelines used as part of the assessment tools to assess patients' needs. These included the Malnutrition Universal Screening Tool (MUST) a validated nutritional screening tool. It is a simple five step tool designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk.

Patient records demonstrated that MUST was used to assess and record patient’s nutrition and hydrational needs. However, we found instances when the MUST assessment was not used correctly. For example, missing weight and height information. We reviewed nutrition audit data from the safe staffing reports for February to March 2018 for the surgery wards. Audit results show that C2 and C4 had 100% compliance for February and March respectively. Audit results for the other wards, C3, D1, D3, D4 and the Diagnostic Treatment Centre (DTC) at the Basingstoke site and Bartlett, Kemp Welch, St Cross, Wainwright ward and the surgical short stay unit showed audit data ranged from 30% to 93% or no reports reported.

Nursing and medical handovers we observed on the surgical wards showed patient’s eating and drinking needs were discussed at handover. This included if or when the patient should be nil by
mouth due to their upcoming surgery, if they required a special diet or to be seen by the dietitian for any reason.

We were told some wards, for example C2 the pseudomyxoma specialist ward, had designated dietitians to help care for the nutritional needs of the patients.

Patients for surgery were kept nil by mouth in accordance to the Royal College of Anaesthesia guidelines. Elective patients received clear guidance about when to eat and drink before their surgery.

The trust had introduced a new way of ordering food on an electronic meal ordering system on the wards. Patients we spoke with liked the system and said it was easy to use. On most of the wards we inspected the housekeeper was responsible for the distribution of food at meal times. Staff offered support to those patients who needed help or who had dietary restrictions. Those patients were identified by using a red tray at meal times. Patients reported mixed feedback about the quality of the food, with some saying it was very good, some saying it was poor and one patient describing it as ‘pretty diabolical’.

On the wards we inspected, we observed water jugs by patient’s beds and chairs and these were placed within patients’ reach.

Patients on the pre-assessment units had access to a water cooler and tea and coffee making machines. Staff told us if the patients were there for greater than four hours they would be able to supply snacks or sandwiches for them. This was the same for patients on any of the short stay units at BNHH and RHCH, we were told that snacks and sandwiches were kept on the units to be offered to patients if required.

The wards used fluid balance charts and food charts to record the patients’ intake and output and completion.

Pain relief

Andover War Memorial Hospital

Staff assessed and monitored patients regularly to see if they were in pain.

We were told by staff that patients’ pain was assessed by staff and pain relief was prescribed as required. During our inspection we did not see any patient’s requiring pain medication.

Staff had access to the trust-wide pain management team. However, none of the team of specialist doctors and nurses, clinical psychologists, specialist physiotherapists or occupational therapists were based at Andover War Memorial Hospital. Staff referred patients to the main trust sites of BNHH or RHCH if required.

If patients needed analgesics at home after day unit surgery, they would be given TTOs (to take out) medication that had been pre-prepared by the Winchester pharmacy department as there was no pharmacy department based on the Andover site.

Basingstoke and North Hampshire Hospital / Royal Hampshire County Hospital

Staff assessed and monitored patients regularly to see if they were in pain.

Patients were given advice about pain when attending their preoperative assessment and had information about the different types of pain relief they might receive following their surgery. We
observed a patient after undergoing day surgery being given information of how and whom to contact in case they were having pain after the procedure.

Patients we spoke with on the surgical wards of both hospitals were positive about their pain management. We were told by a patient on Kemp Welsh ward at RHCH that when they required pain relief the nurse would go and get it and if they were unable to administer pain relief they would always explain why. Another patient told us they were regularly offered pain relief but the patient had not required it. However, we were told by a patient on St Cross’s ward at RHCH that ‘although he had asked for pain relief he was still waiting for it but he understood as the nurses were very busy and couldn’t always do things immediately’.

We were told by staff there was a process for assessment of patients’ pain using a recognised pain assessment tool.

Staff had access to the pain management team. The specialist team of doctors and nurses, clinical psychologists, specialist physiotherapists or occupational therapists that run the service were spread across the two sites. We were told there were guidelines in place on how to access the service if you needed it quickly for inpatients.

Sustained release analgesia was prioritised by pharmacy to ensure patients’ pain was managed.

For more chronic pain requirements, pain that had existed for longer than three months, patients would usually be seen in an outpatient setting by the pain management team.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From December 2016 to November 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma & orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing Elective Admissions – Trust Level](image)

*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 represents the opposite. Top three specialties for specific trust based on count of activity*

All patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- General surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & orthopaedics patients at the trust had a similar risk of readmission for non-elective admissions when compared to the England average.
- Colorectal surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

![Graph showing non-elective admissions](image)

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 represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (December 2016 – November 2017))

**Basingstoke and North Hampshire Hospital**

From December 2016 to November 2017, all patients at Basingstoke and North Hampshire Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- Trauma & orthopaedics patients at Basingstoke and North Hampshire Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Basingstoke and North Hampshire Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Ophthalmology patients at Basingstoke and North Hampshire Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - **Basingstoke and North Hampshire Hospital**

![Graph showing elective admissions](image)

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 represents the opposite. Top three specialties for specific trust based on count of activity

All patients at Basingstoke and North Hampshire Hospital had a similar expected risk of readmission for non-elective admissions when compared to the England average.

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expected risk of readmission for non-elective admissions when compared to the England average.

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- Urology patients at Basingstoke and North Hampshire Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions - Basingstoke and North Hampshire Hospital**

[Graph showing readmission rates for different specialties at Basingstoke and North Hampshire 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 represents the opposite. Top three specialties for specific trust based on count of activity.*

**Royal Hampshire County Hospital**

From December 2016 to November 2017, all patients at Royal Hampshire County Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.

- Trauma & orthopaedics patients at Royal Hampshire County Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Ophthalmology patients at Royal Hampshire County Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at Royal Hampshire County Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - Royal Hampshire County Hospital**

[Graph showing readmission rates for different specialties at Royal Hampshire County 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 represents the opposite. Top three specialties for specific trust based on count of activity.*

All patients at Royal Hampshire County Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at Royal Hampshire County Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
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expected risk of readmission for non-elective admissions when compared to the England average.

- Colorectal surgery patients at Royal Hampshire County Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions - Royal Hampshire County Hospital**

![Graph showing non-elective admissions rate](image)

*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 represents the opposite. Top three specialties for specific trust based on count of activity.*

(Source: Hospital Episode Statistics)

**National Hip Fracture Database**

**Basingstoke and North Hampshire Hospital:**

In the 2017 National Hip Fracture Database for Basingstoke and North Hampshire Hospital, the risk-adjusted 30-day mortality rate was 7%, which was as expected compared to the England average of 6.7%. The 2016 figure was 6.5%.

The proportion of patients having surgery on the day of or day after admission was 83.7%, which falls in the top 25% of trusts but was worse than the national standard of 85%. The 2016 figure was 82.4%.

The perioperative medical assessment rate was 92.7%, which failed to meet the national standard of 100%. The 2016 figure was 93%.

The proportion of patients not developing pressure ulcers was 95.4%, compared to 95.6% national aggregate, which falls in the middle 50% of trusts. The 2016 figure was 96%.

The length of stay was 25.4 days, which falls in the middle 50% of trusts. The 2016 figure was 23.7 days.

**Royal Hampshire County Hospital:**

In the 2017 National Hip Fracture Database for Royal Hampshire County Hospital, the risk-adjusted 30-day mortality rate was 5.4% which was as expected. The 2016 figure was 4.9%.

The proportion of patients having surgery on the day of or day after admission was 90.3%, which falls in the top 25% of trusts and was better than the national standard of 85%. The 2016 figure was 83.1%.

The perioperative medical assessment rate was 88.9%, which failed to meet the national standard of 100%. The 2016 figure was 90.7%.

The proportion of patients not developing pressure ulcers was 97.2%, which falls in the middle 50% of trusts. The 2016 figure was 98.2%.
The length of stay was 28.1 days, which falls in the bottom 25% of trusts. The 2016 figure was 23 days.

(Source: National Hip Fracture Database 2017)

National Bowel Cancer Audit

Basingstoke and North Hampshire Hospital:

In the 2017 National Bowel Cancer Audit for Basingstoke and North Hampshire Hospital, 75.6% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 87%.

The risk-adjusted 90-day post-operative mortality rate was 0% which was within expected range. The 2016 figure was not reported.

The risk-adjusted 2-year post-operative mortality rate was 12.2% which was within expected range. The 2016 figure was 17.2%.

The risk-adjusted 30-day unplanned readmission rate was 5.5% which was within expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 28.4% which was a positive outlier. The 2016 figure was 26.4%.

Royal Hampshire County Hospital:

In the 2017 National Bowel Cancer Audit for Royal Hampshire County Hospital, 73.9% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 74.3%.

The risk-adjusted 90-day post-operative mortality rate was 4.9% which was within expected range. The 2016 figure was 1.3%.

The risk-adjusted 2-year post-operative mortality rate was 8.9% which was better than expected. The 2016 figure was 16.2%.

The risk-adjusted 30-day unplanned readmission rate was 9% which was within expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 30.2% which a positive outlier. The 2016 figure was 36.3%.

(Source: National Bowel Cancer Audit 2017)

National Vascular Registry

Hampshire Hospitals NHS Foundation Trust did not participate in the 2017 National Vascular Registry (NVR).

(Source: National Vascular Registry 2017)

National Oesophago-Gastric Cancer Audit

In the 2016 Oesophago-Gastric Cancer National Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 1.4%. Patients diagnosed
after an emergency admission are less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 0%.

The 90-day post-operative mortality rate was not eligible in the last two audits.

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)

**Andover War Memorial Hospital**

Andover War Memorial hospital did not participate in national audits. There were no audits this service should be participating in as they were undertaking minor surgery.

**Basingstoke and North Hampshire Hospital / Royal Hampshire County Hospital**

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 Emergency Laparotomy Audit**

**Basingstoke and North Hampshire Hospital:**

In the 2016 National Emergency Laparotomy Audit (NELA), Basingstoke and North Hampshire Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 92 cases.

Basingstoke and North Hampshire Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 78 cases.

Basingstoke and North Hampshire Hospital achieved 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 48 cases.

Basingstoke and North Hampshire Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 28 cases.

The risk-adjusted 30-day mortality for the Basingstoke and North Hampshire Hospital was within expectations, based on 92 cases.

**Royal Hampshire County Hospital:**

In the 2016 National Emergency Laparotomy Audit (NELA), Royal Hampshire County Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 109 cases.

Royal Hampshire County Hospital achieved a green rating for the crude proportion of cases with
access to theatres within clinically appropriate time frames. This was based on 71 cases.

Royal Hampshire County Hospital achieved 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 60 cases.

Royal Hampshire County Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 46 cases.

The risk-adjusted 30-day mortality for the Royal Hampshire County Hospital was within expectations, based on 109 cases.

Green ratings show a positive outlier (below 99.8% control limit), whereas red ratings show a negative outlier (above 99.8% control limit).

(Source: National Emergency Laparotomy Audit 2016)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are 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 2015/16 performance on groin hernias was better than the England average, whilst performance for hip replacements and knee replacements were both about the same as the England Average. For varicose veins, no information was available for this trust’s performance.

(Source: NHS Digital)

Competent staff

Trust wide
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.

**Appraisal rates**

From April 2017 to February 2018, 60.0% of staff at Andover War Memorial Hospital, 61.0% of staff within surgery at Basingstoke and North Hampshire Hospital and 51.6% of staff at Royal Hampshire County Hospital had received an appraisal compared to a trust target of 80% for non-medical staff and 90% for medical staff.

A split by site and staff group can be seen in the tables at the start of each hospital information:

**Andover War Memorial Hospital:**

<table>
<thead>
<tr>
<th>Staffing groups</th>
<th>Number completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>5</td>
<td>9</td>
<td>55.6%</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>15</td>
<td>60.0%</td>
</tr>
</tbody>
</table>

Nursing staff at Andover War Memorial Hospital had a completion rate of 55.6%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The trust had an induction programme for newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules.

Staff we spoke with told us the learning and development team delivered training locally to the team three times a year.

We saw posters in the staff room advertising ‘lunch & learn’ sessions these occurred once a month and covered topics such as attitude and manner, skincare, mentorship and waste within Hampshire Hospital Foundation Trust.

The surgical team had team meetings but there were no formal arrangements for staff’s supervision in order to identify staff’s development and training needs. Although we were told during the inspection that clinical supervision was going to be rolled out to the team, starting first with the band 6 nurses, then in time would be rolled out to the band 5 nurses and the healthcare assistants.

Due to long term staff sickness in the team the department was currently not taking student nurses.

**Basingstoke and North Hampshire Hospital**

**Appraisal rates**

<table>
<thead>
<tr>
<th>Staffing groups</th>
<th>Number completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>60</td>
<td>81</td>
<td>74.1%</td>
</tr>
</tbody>
</table>
Support to ST&T staff | 2 | 3 | 66.7%
Qualified nursing & health visiting staff | 153 | 243 | 63.0%
Qualified Allied Health Professionals | 9 | 15 | 60.0%
Support to doctors and nursing staff | 119 | 203 | 58.6%
Qualified Healthcare Scientists | 1 | 2 | 50.0%
NHS infrastructure support | 14 | 29 | 48.3%
Other Qualified Scientific, Therapeutic & Technical staff | 0 | 11 | 0.0%
Total | 358 | 587 | 61.0%

Medical/dental staff at Basingstoke and North Hampshire Hospital had a completion rate of 74.1%, whilst 63.0% of nursing staff had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The trust had an induction programme for newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules.

Surgical wards and departments had ward specific training programs for their staff. For example, in the Diagnostic Treatment Centre (DTC) new staff would rotate round the department, completing a competent training package in each area. They would be mentored by a band 5 on the wards and a band 6 when in the theatre environment.

Theatre new starters had a specific induction booklet with competencies to work through, this was the same across the BNHH and RHCH sites.

Pre-assessment nursing staff told us they were trained in the skills they needed in the department, this included phlebotomy, ECGs, physical examinations and patient history taking. Only once staff were deemed competent could they carry out these practices. The department had invested in train the trainer programs to help deliver the training to others in the unit.

Staff working on the surgical wards and departments told us they had access to clinical nurse specialists (CNS), link nurses and the specialist outreach team who provided advice and support for patients and staff in different areas including pain management, infection control and stoma care.

The hospital had adopted the Collaborative Learning in Practice (CLiP) model which encouraged students to take the lead in their practice, caring for their own patient group and supporting the learning through identified daily learning outcomes rather than one to one mentoring. We spoke with student nurses working on C3 ward who liked this way of learning and felt it gave them many learning opportunities but in a safe environment.

We were told by staff that internal development was encouraged for example, being told staff could progress to a senior band 5 once their competencies had been completed and staff on the orthopaedic wards told us how they had come in as generalists and been trained in orthopaedics by the trust.

We were told by staff on many of the wards about the training opportunities open to them, for example, support given to complete English examinations; we spoke with qualified staff nurses that had started at the trust as associate practitioners; therapists had completed a quality improvement course to help improve written communication between therapists and relatives. However, staff did tell us they would like a greater training budget so they could access relevant external training courses.
Medical/dental staff at Royal Hampshire County Hospital had a completion rate of 73.9%, whilst 49.4% of nursing staff had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The trust had an induction programme for newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules.

Surgical wards and departments had ward specific training programs for their staff. For example, staff that worked in theatres had further training in the wearing of scrubs, and the skills required to work in the recovery unit of theatres and all members of staff on Bartlett ward had a competency folder to work through.

Theatre new starters had a specific induction booklet with competencies to work through, this was the same across the BNHH and RHCH sites.

Pre-assessment nursing staff told us they were trained in the skills they needed in the department, this included ECGs, physical examinations and patient history taking. Only once staff were deemed competent could they carry out these practices. However, nursing staff did not carry out venepuncture, instead patients were sent to the phlebotomy clinic to have blood samples taken.

Staff working on the surgical wards and departments told us they had access to clinical nurse specialists (CNS), link nurses and the specialist outreach team who provided advice and support for patients and staff in different areas including pain management, infection control and learning disabilities.

We were told by staff internal development was encouraged, we were told of staff course in areas such as tissue viability, the orthopaedic wards told us how they had come in as generalists and were being trained in orthopaedics by the trust and Bartlett ward had weekly training afternoons which included attendance by the physiotherapists and occupational therapists.

We were told by staff on many of the wards about the training opportunities open to them, for example, the healthcare assistants (HCAs) working in theatres were encouraged to train in

### Royal Hampshire County Hospital

#### Appraisal rates

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<td>51</td>
<td>69</td>
<td>73.9%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>8</td>
<td>13</td>
<td>61.5%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>9</td>
<td>15</td>
<td>60.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>4</td>
<td>7</td>
<td>57.1%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>77</td>
<td>156</td>
<td>49.4%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>64</td>
<td>148</td>
<td>43.2%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>0</td>
<td>5</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>213</strong></td>
<td><strong>413</strong></td>
<td><strong>51.6%</strong></td>
</tr>
</tbody>
</table>
advanced life support (ALS) to help become operating department practitioners (ODPs) and a HCA working on the wards was encouraged to go to university to train as a physician’s associate.

We were told by staff that there were two professional development leads (PDLs) working at RHCH who staff could contact regarding their professional development needs. However, one was currently on maternity leave and this post had not been covered in the meantime.

We spoke with junior doctors who told us they had structured protected teaching sessions at least once a week and informal training during medical handovers. They told us they could access consultants for help and advice where necessary. In addition, junior doctors had a clinical supervisor who provided support for their formal portfolios.

**Multidisciplinary working**

**Andover War Memorial Hospital**

Staff did not consistently work well together as a team to benefit patients.

Staff told us there was a good working rapport between all staff working within the day surgery unit and at Andover War Memorial Hospital. We saw evidence of this during our inspection. All staff regardless on grade or role had helpful, friendly and professional interactions with each other.

Access to specialist advisors or other services such as therapist input, pharmacy support and the resuscitation team was via the RHCH site at Winchester. During our inspection we saw evidence and heard from staff that they did not always receive the support they felt they needed. For example, we were told by nursing staff that there had been no visits by the pharmacy team for the past four months due to staff shortages, despite there being a pharmacy rota for the hospital site.

**Basingstoke and North Hampshire Hospital**

Staff of different kinds worked well together as a team to benefit patients. Doctors, nurses and other healthcare professionals mostly supported each other to provide good care.

Nursing and medical teams carried out their handovers separately and without input from the physiotherapy or occupational therapy teams. However, most wards carried out MDT huddles later in the day where patients were discussed with input from a variety of teams which could include, doctors and nurses, physiotherapists, occupational therapists, dieticians.

The Diagnostic Treatment Centre (DTC) had an early morning MDT meeting where all issues and resources were discussed for that day. Like the surgical wards they had MDT huddles twice daily to discuss patients and any issues arising.

Staff we spoke with said that different teams worked well together and during our inspection we were told and saw members of different teams working together. Nurses and occupational therapists were involved in both the pre- and post-operative care of patients which helped to get the best results for patients after surgery and we saw the main theatre team working cohesively.

On C2 the Peritoneal Malignancy ward, we saw effective MDT working. Due to the complex nature of the condition a specialist team of medical and nursing staff, physiotherapists, pharmacists, psychologists and nutritionists plus other supporting teams worked closely together to provide the treatment and care needed by the patient.
During our inspection we were told of the support available by other specialist teams working in the hospital for example, we were told the mental health liaison team was responsive when they were needed and there was a complex discharge team.

We were told by allied healthcare professionals on D4 ward that it was sometimes necessary for them to help with clinical duties for example, with patient mealtimes when there was nursing staff shortages on the ward.

**Royal Hampshire County Hospital**

Staff of different kinds worked well together as a team to benefit patients. Doctors, nurses and other healthcare professionals mostly supported each other to provide good care.

Nursing and medical teams carried out their handovers separately and without input from the physiotherapy or occupational therapy teams. However, most wards carried out MDT huddles later in the day where patients were discussed with input from a variety of teams which could include, doctors and nurses, physiotherapists, occupational therapists, dieticians. We were told on Bartlett ward there was a daily afternoon MDT huddle which would involve the orthogeriatrician, physiotherapist, occupational health therapist, social worker and ward sister.

Staff we spoke with said that different teams worked well together and during our inspection we were told and saw members of different teams working together. Nurses and occupational therapists were involved in both the pre- and post-operative care of patients which helped to get the best results for patients after surgery and we were told that the stoma nurses worked closely with the surgeons on Wainwright ward.

During our inspection we were told of the support available by other specialist teams working in the hospital. We saw evidence of MDT working between the ward staff on Bartlett ward and the Palliative Care Team and the Dementia Co-ordinator.

We were told that the stoma nurses worked closely with the ward staff on Wainwright ward and would often help when there was nursing staff shortages on the ward. The stoma nurse would also cover for the ward clerk when they were on leave.

**Seven-day services**

**Andover War Memorial Hospital**

The day surgery unit was operational from 8am to 6pm Monday to Friday only.

There was no pharmacy department at the hospital and no dedicated physiotherapists or occupational health therapists attached to the unit.

**Basingstoke and North Hampshire Hospital**

Surgical and trauma emergency services were available seven days a week at the hospital. Elective surgery was available Monday to Friday and could be available on a Sunday if needed. There were no plans to develop a seven-day elective surgical service.

There was consultant cover 24 hours a day / seven days a week either with a consultant on site or on call. On weekdays a surgical consultant was present on site between 8am to 6pm and there was non-resident cover between 6pm and 8am. At the weekends a surgical consultant would be
present for the 8am ward rounds then if there were no planned operations there would be non-resident cover thereafter.

There was a separate weekend specialty rota for C2 the pseudomyxoma ward, where ward rounds happened two hourly during the day. There would be specialty non-resident cover thereafter.

The critical care outreach team was available 24 hours a day, seven days a week to access and provide support for deteriorating patients on the surgical wards.

Physiotherapy services and occupational therapists were provided seven days a week. However, due to reduced staffing levels at the weekend, not all patients received therapy. Staff prioritised to patients with the greatest clinical need, for example patients on the orthopaedic ward who had undergone surgery on the Friday.

Pharmacy services were available five days a week from 9am to 5pm. The main hospital pharmacy was open 08:45 to 5pm Monday, Tuesday, Thursday and Friday; 9:30am to 5pm on Wednesday and 9:15am to 1pm on Saturday and Sunday. There was an on-call service outside of these hours.

The Chaplaincy Team provided spiritual and pastoral care, seven days a week, 24 hours a day, to patients, visitors and staff. The chapel was open 24 hours a day for quiet reflection.

Royal Hampshire County Hospital

Surgical and trauma emergency services were available seven days a week at the hospital. Elective surgery was available Monday to Friday and could be available at the weekend if needed. There were no plans to develop a seven-day elective surgical service.

There was consultant cover 24 hours a day, seven days a week either with a consultant on site or on call. On weekdays a surgical consultant was present on site between 8am to 6pm and there was non-resident cover between 6pm -8am. At the weekends a surgical consultant would be present for the 8am ward rounds then if there were no planned operations there would be non-resident cover thereafter.

The critical care outreach team was available seven days a week, 24 hours a day to access and provide support for deteriorating patients on the surgical wards.

Physiotherapy services and occupational therapists were provided seven days a week. However, due to reduced staffing levels at the weekend, services were prioritised to patients with the greatest clinical need, for example patients on the orthopaedic ward who had undergone surgery on the Friday.

Patient outpatient pharmacy services were available five days a week from 9am to 5pm. The main hospital pharmacy was open 08:45 to 5pm Monday, Tuesday, Thursday and Friday; 9:30am to 5pm on Wednesday and 9:15am to 1pm on Saturday and Sunday. There was an on-call service outside of these hours.

The Chaplaincy Team provided spiritual and pastoral care, seven days a week, 24 hours a day, to patients, visitors and staff. The chapel was open 24 hours a day for quiet reflection.

Health promotion

Andover War Memorial Hospital
Patients 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 treatment.

We saw some health promoting leaflets and posters displayed in the waiting room of the day surgery unit.

**Basingstoke and North Hampshire Hospital**

Patients 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 treatment.

We saw a range of health promoting leaflets and posters displayed in the surgical wards including information on alcohol awareness and how to stop smoking. We were not told if these leaflets were available in other languages than English.

We saw that leaflet and booklets were available and given to patients after their pre-assessments in both the pre-assessment unit and the diagnostic treatment centre. Depending on the issue, patients would be signposted to the relevant organisations or to their GPs.

Basingstoke and North Hampshire Hospital, since April 2018, was taking part in the PJ paralysis challenge. This was an initiative to get patients up out of bed and dressed every day. It has been shown that having patients in their day clothes whilst in hospital reduces fall, improves patient experience and reduces length of stay.

**Royal Hampshire County Hospital**

Patients 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 treatment.

We saw a range of health promoting leaflets and posters displayed in the surgical wards including information on alcohol awareness and how to stop smoking. We were not told if these leaflets were available in other languages than English.

We saw that leaflets and booklets were available and given to patients after their pre-assessments in both the pre-assessment unit and the treatment centre/short stay surgical unit. We were not told if these were available in other languages than English.

Depending on the issue, patients would be signposted to relevant organisations or to their GPs. For example, nursing staff in the pre-assessment would refer patients with a body mass index too high for surgery to their local GP or to a weight loss organisation.

Royal Hampshire County Hospital, since April 2018, was taking part in the PJ paralysis challenge. This was an initiative to get patients up out of bed and dressed every day. It has been shown that having patients in their day clothes whilst in hospital reduces fall, improves patient experience and reduces length of stay.

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

There was no mandatory trust training in the Mental Capacity Act or Deprivation of Liberty Safeguards (DoLs) for staff. However, the trust reported that from April 2017 to February 2018 Mental Capacity Act (MCA) training has been completed by 67.7% of staff within surgery. Medical/dental staff had a completion rate of 64.7% and nursing staff had 71.6% completion rate.

The trust reported that the Deprivation of Liberty training is encompassed in the MCA training module and was not a separate course. Deprivation of Liberty training was not mandatory, although the current training completion rate is 69% trust wide.

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

Andover War Memorial Hospital

Patients were asked for their consent to care and treatment. Staff told us if they were worried about a patient’s mental capability to give consent they would seek advice from senior team members.

For patients undergoing many of procedures at the day surgery unit nurses completed the patients’ consent for the procedures, with the procedures being performed by a doctor. The nurses had not received formal training in the consent process to undertake this role but had received on the job training by medical staff.

Patients were given clear explanations about the surgery and procedures being performed and staff checked that they understood what they were consenting to. We were told by nursing staff that during the consent stage patients would be informed that the unit operated mixed sexed lists and the recovery area was mixed sexed.

Basingstoke and North Hampshire Hospital

We were not assured that staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There were trust policy and procedures to follow when patients could not give consent.

When we spoke with staff in the diagnostic treatment centre we were told that they do not usually have patients with mental capacity issues or requiring Deprivation of Liberty safeguards (DoLs). However, if they did they would call social services for advice.

Staff we spoke with seemed unaware of trust policy and procedures in Mental Health Act (MCA) and DoLs and told us they would escalate to senior staff.

Patients gave written consent for treatment prior to having an operation. This was completed pre-operatively in an outpatient clinic by a consultant and verbally checked on admission. We observed staff taking consent in theatres and checking against consent forms and patient IDs.

We observed a patient’s journey in the ophthalmic day surgery and the patient was informed and could ask questions throughout the procedure.

We observed during nurses and medical handover that patients do not attempt cardiopulmonary resuscitation status was included on the handover notes.

Between March 2017 – February 2018 staff on the surgical wards made 22 deprivation of liberty safeguards (DoLS) applications of which four were approved.
Royal Hampshire County Hospital

We were not assured that staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There were trust policy and procedures to follow when patients could not give consent.

Staff we spoke with seemed aware of some trust policies and procedures in the Mental Health Act (MCA) and DoLs and told us they would escalate to senior staff. However, we were told about the trust policy regarding the administration of covert medication for individual patients who had learning difficulties and about the consent form to use for patients without capacity.

Patients gave written consent for treatment prior to having an operation. This was completed pre-operatively in an outpatient clinic by a consultant and verbally checked on admission. We observed staff taking consent in theatres and checking against consent forms and patient IDs.

Between March 2017 – February 2018 staff on the surgical wards made four deprivation of liberty safeguards (DoLS) applications of which none were approved.

Is the service caring?

Compassionate care

From March 2017 to February 2018 the friends and family test response rate for surgery at Hampshire Hospitals NHS Foundation Trust was 32% which was better than the England average of 29%.

(Source: NHS England Friends and Family Test)

Andover War Memorial Hospital

Staff cared for patients with compassion.

Although Friends and family test feedback forms were available in the day surgery unit the trust did not provide us with individual data for the unit.

We observed many pleasant interactions between staff and patients. Staff spoke with patients and relatives in a kindly manner, using supportive language. All patients were treated in a respectful and reassuring way.

We observed a nurse on the telephone talking with a patient in a friendly and informative way.

Although the trust reported no mixed sexed breaches, the day surgery unit at Andover War Memorial Hospital operated mixed sexed surgical lists with the recovery area being mixed sexed. Other than the curtains between bays there was no measures to ensure patients privacy and dignity were maintained. Staff were not aware of mixed sex breaches and this was not reported.

Basingstoke and North Hampshire Hospital:

Friends and Family test performance

Basingstoke and North Hampshire Hospital (BNHH) had a response rate of 36% (based on 3,025 responses)

A breakdown of the friends and family test performance by ward for surgical wards at BNHH with
total responses over 100 is below. The monthly figures show recommendation percentage and not response rates.

Friends and family Test – Response rate from March 2017 to February 2018 by ward

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Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

Ward C3 had the lowest response rate with 22%, whilst ward C2 had the highest response rate with 56%.

(Source: NHS England Friends and Family Test)

Staff mostly cared for patients with compassion or respect their privacy and dignity.

During our inspection we observed that FFT feedback forms were available on the wards. Many of the wards displayed the number of responses and the percentage of patients recommending the service for the previous month on display boards.

We observed many pleasant interactions between staff and patients. Staff spoke with patients and relatives in a kindly manner, using supportive language.

We saw compliments received from patients with many wards displaying thank you cards in ward areas.

When we spoke with patients on the surgical wards and in the diagnostic treatment centre we were told of the positive ways they had been treated with many commenting on the lovely staff and the good care they received.

However, we observed a member of staff treating a confused and vulnerable patient in a disrespectful way, this patient needed one to one care and had been flagged at handover as being confused. We were also concerned about the patient’s privacy and dignity as their medical details were being discussed loudly and the patient was in a state of undress. We raised our concerns at the time to the clinical matron of the ward.

On D3 ward we were told by several patients of the unkind working practices by an overnight nurse. They were rude to patients and did not put patients at the centre of what they did. Patients had complained to senior nursing staff on the ward but had seen no change in the nurse’s attitude. We raised our concerns at the time to the chief nurse who took appropriate action.

We did see patient’s dignity being respected by staff, with the closing of curtains when patients required privacy on the wards and the knocking on room doors before entering the patient’s room. However, although the trust reported no mixed sexed breaches, the Diagnostic Treatment Centre (DTC) had a mixed sexed recovery area, the surgical assessment unit (SAU) situated on ward C3 and the pre-assessment unit used mixed sexed wards. In all these areas mixed sexed surgical
lists were in operation and other than the normal curtains between bays there was no physical measures to ensure patients privacy and dignity were maintained.

We had concerns that white boards, which were located in busy corridors on the surgical wards, displayed patient’s full names and their location on the ward. This did not maintain patient’s privacy. When we raised our concerns to staff it was not considered a problem.

In the pre-assessment unit the computer screen used to review patient information i.e. x-rays and scans was attached to the wall on the main corridor in the unit. This screen was directly opposite the unit’s reception desk. This corridor was also the main access to and from the discharge lounge. The location of the screen did not protect patients’ privacy and dignity.

Royal Hampshire County Hospital:

Royal Hampshire County Hospital (RHCH) had a response rate of 27% (based on 1,708 responses).

A breakdown of the friends and family test performance by ward for surgical wards at RNCH with total responses over 100 is below. The monthly figures show recommendation percentage and not response rates.

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Kemp Welch ward had the lowest response rate with 11%, whilst Wykeham ward had the highest response rate with 60%.

(Source: NHS England Friends and Family Test)

Staff cared for patients with compassion but patient’s privacy and dignity was not always respected.

During our inspection we observed that FFT feedback forms were available on the wards. Many of the wards displayed the number of responses and the percentage of patients recommending the service for the previous month on display boards in the corridors for patients to see.

We observed many pleasant interactions between staff and patients. Staff spoke with patients and relatives in a kindly manner, using supportive language.

We saw compliments received from patients with many wards displaying thank you cards in ward areas.

When we spoke with patients on the surgical wards we were told of the positive ways they had been treated, with many commenting on the lovely staff and the good care they received. We were given names of staff that patients felt had given them excellent care and told of how a simple smile from staff could make their hospital experience that much better.
We did see patient’s dignity being respected by staff, with the closing of curtains when patients required privacy on the wards. However, although the trust reported no mixed sexed breaches, the pre-assessment unit and the surgical assessment unit (SAU) situated on Kemp Welch ward used mixed sexed wards. In both these areas mixed sexed patient lists were in operation and other than the normal curtains between bays there was no physical measures to ensure patient’s privacy and dignity were maintained.

We had concerns that white boards, which were located in busy corridors on the surgical wards, displayed patient’s full names and their location on the ward and the white board in St Cross ward displayed days post-operation and the patient’s consultant. This did not maintain patient’s privacy. When we raised our concerns to staff it was not considered a problem.

### Emotional support

**Andover War Memorial Hospital**

Staff provided emotional support to patients to minimise their distress.

Throughout our inspection, we observed staff supporting patients, responding to their needs and communicating in an appropriate way.

In one of the patients thank you cards which was displayed in the unit, the patient had commented about the support given to them by a member of the nursing team ‘how lovely it was to have my hand held particularly when it hurt. Afterwards when I was ready for discharge the nurse got a wheelchair and pushed me all the way up the hill to the awaiting taxi’

There was a chaplaincy service that provided spiritual, religious or pastoral support to patients at any time of the day or night. Patient information boards in the hospital contained details of how to contact the service.

**Basingstoke and North Hampshire Hospital**

Staff provided emotional support to patients to minimise their distress.

Throughout our inspection, we observed staff supporting patients, responding to their needs and communicating in an appropriate way.

Patients and relatives told us they received the support they needed to manage their treatment and hospital stay. Patients told us they felt assured by doctors and they felt prepared for their surgery.

We were told by a patient on the ophthalmic day surgery ward that a member of staff had held their hand throughout the procedure as the patient was feeling anxious.

We spoke with a spouse of a patient on C2- the pseudomyxoma specialist ward who had been offered accommodation as staff where concerned of the impact of a long drive each day on the partners health and wellbeing.

Patients had access to the palliative care team, the chaplaincy service and a broad range of specialist nurses to support them whilst they were inpatients.

**Royal Hampshire County Hospital**

Staff provided emotional support to patients to minimise their distress.
Throughout our inspection, we observed staff supporting patients, responding to their needs and communicating in an appropriate way.

Patients and relatives told us they received the support they needed to manage their treatment and hospital stay. Patients told us they felt assured by doctors and they felt prepared for their surgery.

We were told of instances when nurses had gone that extra mile to care for their patient’s emotional needs, for example a nurse had rung a cattery to make sure a patient’s cat was doing OK as the patient was worried about their pet, and a nurse had styled a patient’s hair as they had been told by the patient that it made them ‘feel more human’.

Patients had access to the palliative care team, the chaplaincy service and a broad range of specialist nurses to support them whilst they were inpatients.

Understanding and involvement of patients and those close to them

**Andover War Memorial Hospital**

Staff involved patients and those close to them in decisions about their care and treatment.

Patients were involved in the care and provided with information. Patient’s families were involved as appropriate. During our inspection we saw evidence of this with a nurse explaining the upcoming procedure and what happened after discharge to an elderly patient and their family.

**Basingstoke and North Hampshire Hospital**

Staff involved patients and those close to them in decisions about their care and treatment.

Patients we spoke with confirmed that their treatment had been discussed with them throughout their journey; prior to their surgery, when admitted and post-surgery and that they felt able to make informed decisions.

During our inspection we observed clinical staff including patients, whether it be during medical rounds or when occupational therapists on C4 ward were discussing post-operative care plans with their patients.

**Royal Hampshire County Hospital**

Staff involved patients and those close to them in decisions about their care and treatment.

Patients we spoke with confirmed that their treatment had been discussed with them throughout their journey; prior to their surgery, when admitted and post-surgery and that they felt able to make informed decisions.

During our inspection we observed clinical staff including patients. For example, we observed a physiotherapist discussing mobility plans with a patient and their relations on Kemp Welch ward and we followed a patient’s journey through their surgery in the pain management theatre, we observed the patient being informed on what was happening and their questions were answered by staff.

Patients for elective surgery with specific cultural or religious needs were able to access alternatives products to blood transfusions.
Is the service responsive?

Service delivery to meet the needs of local people

Trust Wide

Average length of stay

Trust Level – elective patients

From January 2017 to December 2017, the average length of stay for all elective patients at the trust was 3.4 days, which is lower compared to the England average of 3.9 days.

- For trauma & orthopaedics elective patients at the trust was 2.8 days, which is lower compared to the England average of 3.9 days.
- For urology elective patients at the trust was 2.3 days, which is as expected compared to the England average of 2.5 days.
- For general surgery elective patients at the trust was 3.6 days, which is slightly lower compared to the England average of 3.9 days.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 5.5 days, which is higher compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at the trust was 3.3 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at the trust was 9.7 days, which is higher compared to the England average of 8.7 days.
- The average length of stay for colorectal surgery non-elective patients at the trust was 5.0 days, which is higher compared to the England average of 4.4 days.

Non-Elective Average Length of Stay – Trust Level
Andover War Memorial Hospital

Andover War Memorial Hospital provided minor surgery in a day surgery unit to patients living in Andover and the surrounding areas. Patients were referred by the consulting doctor in outpatients or by GP referral.

The day surgery unit carried out short procedures normally requiring one hour in the department, with one stop clinics for colorectal and gynaecology procedures and some longer procedures including cataract surgery.

The trusts data showed that between June 2017 and May 2018 theatre utilisation rates for the two theatres were poor. Theatre 1 had an average utilisation rate of 38.3%, minimum usage of 31% in Jan 2018 and maximum of 46% in May 2018. Theatre 2 had an average utilisation rate of 34.9%, minimum usage of 31% in December 2017, February 2018 & May 2018 and maximum of 54% in November 2017.

Patients and staff we spoke with told us that the facility was highly regarded by the local community with many preferring to attend here than the other two hospitals in the trust. This was due to day surgery environment being smaller and less busy and the ease of parking at the hospital.

Basingstoke and North Hampshire Hospital

The service made efforts to plan and provide services in a way that met the needs of local people.

From January 2017 to December 2017 the average length of stay for all elective patients at Basingstoke and North Hampshire Hospital was 4.0 days, which is as expected compared to the England average of 3.9 days.

- The average length of stay for trauma & orthopaedics elective patients at Basingstoke and North Hampshire Hospital was 2.4 days, which is lower compared to the England average of 3.9 days.
- The average length of stay for colorectal surgery elective patients at Basingstoke and North Hampshire Hospital was 11.2 days, which is higher compared to the England average of 7.1 days.
- The average length of stay for general surgery elective patients at Basingstoke and North Hampshire Hospital was 5.4 days, which is higher compared to the England average of 3.9 days.

Elective Average Length of Stay - Basingstoke and North Hampshire Hospital

Note: Top three specialties for specific trust based on count of activity.
Basingstoke and North Hampshire Hospital - non-elective patients

The average length of stay for all non-elective patients at Basingstoke and North Hampshire Hospital was 4.9 days, which is as expected compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at Basingstoke and North Hampshire Hospital was 3.1 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at Basingstoke and North Hampshire Hospital was 8.1 days, which is lower compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at Basingstoke and North Hampshire Hospital was 3.8 days, which is higher compared to the England average of 2.9 days.

Non-Elective Average Length of Stay - Basingstoke and North Hampshire Hospital

![Graph showing average length of stay for different specialties at Basingstoke and North Hampshire Hospital compared to England average.](Image)

*Note: Top three specialties for specific trust based on count of activity.*

(Source: Hospital Episode Statistics)

There was provision for a dedicated emergency surgical theatre list every afternoon starting at 1.30pm and finishing at 5.30pm. However, this was only partially compliant with the Confidential Enquiry into Peri Operative Death (CEPOD) recommendations, which requires these 24 hours per day. We were told by surgical consultants that starting at this time made more sense and utilised theatre time better as it took time to get a patient prepped and ready for surgery and most of the morning would have gone. However, we were also told that if the need arose, emergency patients could be fitted in at the start or during current surgical lists. Emergency surgery was delivered by a clinical team that was free of elective commitments.

The Diagnostic Treatment Centre (DTC) had seven theatres with four providing elective surgery procedures and three endoscopy procedures. The DTC provided elective surgery day surgery in most specialities, including ENT, gynaecology, urology, colorectal. Most patients did not require an overnight stay but there was the facility to stay on the DTC ward if an overnight stay was required. The trusts data showed that between June 2017 and May 2018 the average theatre utilisation rates for the four surgical theatres was 62%, 60%, 62% and 57% (average 60.3%). The DTC also carried out a significant volume of paediatric lists. To accommodate this, paediatric nurses took over the DTC every Monday and alternate Fridays and transformed it into a paediatric only department.

The Eye Day Care unit (EDCU) provided mainly day surgery including cataract removal. One-stop clinics were available after patients attended outpatients and had consultant diagnosis. The trust
data showed that between June 2017 and May 2018 the average theatre utilisation rate for the EDCU was 63% with minimum usage of 54% in July 2018 and maximum of 72% in December 2018.

The main theatre department had seven operating theatres carrying out elective, trauma and emergency surgical cases. Each theatre was dedicated to a specific surgical specialty. The main theatre area had an 11-bay recovery unit which facilitated two high dependency areas that enabled the short term or overnight care of non-ventilated patients. It was unclear if non-surgery high-dependency patients were cared for in this area too. The main theatre department performed surgery in many areas including orthopaedics, urology, colorectal and Pseudomyxoma Peritonei, for which the trust was one of only two national centres for this specialised surgery. The trust’s data showed that between June 2017 and May 2018 the average theatre utilisation rates for the four surgical theatres was 80%, 80%, 78%, 81%, 79% 75% and 74% (average 78.1%). We were told by surgeons that simple paediatric surgery i.e. appendicitis surgery could be performed in children over 5 years but this depended on advice from the anaesthetist. More complex paediatric surgery would be referred to a trust specialising in paediatric surgery.

We spoke with senior staff from the surgical division about the theatre utilisation rates during the inspection. Rates were generally thought of as sub optimal by the team and they thought related to various factors such as the way theatre lists were organised, lack of equipment, last-minute patient cancellations and due to staff sickness or unavailability. There were ideas how to improve this utilisation figure but no plans were seen.

Each specialised surgical area had their own medical secretaries and booking service. This meant there was no centralised booking service for patients.

**Royal Hampshire County Hospital - elective patients**

The service made efforts to plan and provide services in a way that met the needs of local people.

From January 2017 to December 2017 the average length of stay for all elective patients at Royal Hampshire County Hospital was 4.0 days, which is as expected compared to the England average of 3.9 days.

- The average length of stay for trauma & orthopaedics elective patients at Royal Hampshire County Hospital was 4.0 days, which is as expected compared to the England average of 3.9 days.
- The average length of stay for breast surgery elective patients at Royal Hampshire County Hospital was 1.8 days, which is as expected compared to the England average of 1.6 days.
- The average length of stay for colorectal surgery elective patients at Royal Hampshire County Hospital was 6.9 days, which is as expected compared to the England average of 7.1 days.

**Elective Average Length of Stay - Royal Hampshire County Hospital**
Royal Hampshire County Hospital - non-elective patients

The average length of stay for all non-elective patients at Royal Hampshire County Hospital was 7.2 days, which is higher compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at Royal Hampshire County Hospital was 3.9 days, which is as expected compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at Royal Hampshire County Hospital was 14.3 days, which is higher compared to the England average of 8.7 days.
- The average length of stay for colorectal surgery non-elective patients at Royal Hampshire County Hospital was 5.2 days, which is higher compared to the England average of 4.4 days.

Non-Elective Average Length of Stay - Royal Hampshire County Hospital

(Source: Hospital Episode Statistics)

There was provision for an emergency surgical theatre list every afternoon starting at 1.30pm and finishing at 5.30pm. However, this was only partially compliant with the Confidential Enquiry into Peri Operative Death (CEPOD) recommendations, which requires these 24 hours per day. We were told by surgical consultants that starting at this time made more sense and utilised theatre time better as it took time to get a patient prepped and ready for surgery and most of the morning would have gone. However, we were also told that if the need arose, emergency patients could be fitted in at the start or during current surgical lists. Emergency surgery was delivered by a clinical team that was free of elective commitments.

The Treatment Centre and Short Stay Surgical unit (SSSU) had four theatres and provided elective day surgery in most specialities, including ENT, gynaecology, urology, colorectal. Most patients did not require an overnight stay but there was the facility to stay on the SSSU ward if an overnight stay was required. Theatre utilisation data supplied by the trust only gave us theatre
utilisation figures for three of the four theatres. This data showed that between June 2017 and May 2018 the average theatre utilisation rates for the three theatres was 65%, 66%, 61% (average 64%).

There were two theatre suites on the Winchester site, the Nightingale theatres, which comprised of four theatres and the eye theatre situated on Wainwright ward and the Heathcote theatres comprising four theatres. These theatres carried out elective, trauma and emergency surgical case in many areas including orthopaedics, urology and colorectal. Theatre utilisation data supplied by the trust gave us theatre utilisation figures for the five Nightingale theatres. This data showed that between June 2017 and May 2018 the average theatre utilisation rates for the five theatres was 72%, 82%, 76%, 79% and 69% (average 75.6%). The trust only supplied us with the utilisation data from Heathcote A and B theatres. The trust’s data showed that between June 2017 and May 2018 the average theatre utilisation rates for the two surgical theatres was 68% and 74% (average 71%).

We spoke with senior staff from the surgical division about the theatre utilisation rates during the inspection. Rates were generally thought of as sub optimal by the team and they thought related to various factors such as the way theatre lists were organised, lack of equipment, last-minute patient cancellations and due to staff sickness or unavailability. There were ideas how to improve this utilisation figure but no plans were seen.

Royal Hampshire County Hospital operated a centralised administration service for the surgical teams based at the Winchester site, we were told by medical staff this worked well and had improved the services and turn-around times in the service.

**Meeting people’s individual needs**

**Andover War Memorial Hospital**

The service made efforts to take account of patients’ individual needs

During our inspection we saw no evidence of information in languages other than English but we were told by staff that if a patient needed an interpreter then this could be arranged. We were told if the patient required a face to face interpreter this would normally be arranged by the referring GP. Staff told us they had access to a telephone interpreting service. However, they told us that previously they had had to cancel some appointments when the telephone service had no interpreters available. The sister in charge was aware that there was a large Polish and Gurkha population in the local area but no specific services were provided to meet their needs.

The trust had access to a British sign language service for patients with hearing loss. However, none of the staff we spoke with had experience or had the need to access this service.

During our inspection we saw evidence of individual care with an elderly patient being taken into surgery on their bed rather than walking. The patient’s family were allowed to stay with them on the ward whilst they waited for surgery and whilst they recovered following surgery. Staff told us this was common practice to allow relatives of frail patients, who needed extra support from their relatives, to come into the ward area.

Staff told us that patients from the local residential home for people living with disabilities and learning difficulties were admitted and used the services at the day surgery unit. Staff felt they would benefit from specific training to meet the needs of this patient group as they were not confident looking after this patient group.
The day surgery was open plan and did not have separate areas to care for different sexed patients. The unit operated mixed sexed lists daily but did not consider these mixed sexed breaches. As the surgery day unit did not run separate single sexed lists the patient had no choice this may not have met some individual’s needs.

There was level access to the day surgery unit, which was accessible for patients with limited mobility or wheelchair bound. Patients were happy with the parking facilities.

**Basingstoke and North Hampshire Hospital**

The service made efforts to take account of patients’ individual needs

During our inspection we saw no evidence of information in languages other than English but we were told by staff that if a patient needed an interpreter then this could be arranged. We were told by staff on C3 ward that they had used the interpreting service when legal decisions needed to be made with patients. We were told by the occupational therapist on C4 ward that they could provide deaf or blind patients with aids to help communication with them. The sister on the Diagnostic Treatment Centre (DTC) told us they were aware there was a large Polish and Nepalese community in the local area but she was unaware if any special measures had been put in place by the hospital to help with communication.

We were told by staff that they were able to care for patients with learning disabilities or living with dementia. Staff had access to linked nurses and specialist teams if they needed further advice or support. During our inspection we did not observe staff caring for these patient groups, however we were told how staff would use side rooms if possible to reduce distress and liaise with the patient’s carer how best to look after the individual. We were shown communication booklets on C3 ward that were used to aid communication with patients with learning disabilities and the staff at the DTC told us they had processes in place when caring for patients with learning difficulties which included establishing the patient’s individual needs and preferences before admission to the DTC. The surgical wards also told us they supported the John’s Campaign which enabled carers to continue caring for their loved ones throughout their hospital stay should they wish to, the carers would be given badges and had 24-hour access to the wards. The dementia and frailty team also provided 1:1 support to staff for patients living with dementia.

We were told by nursing staff on the surgical wards that patients living with Parkinson’s disease were prioritised for medicine administration and this was communicated on handover sheets.

We were told that patients could be tagged on the electronic patient record system. This allowed staff to identify patients that might require additional support or need support communicating.

**Royal Hampshire County Hospital**

The service made efforts to take account of patients’ individual needs.

During our inspection we saw no evidence of information in languages other than English but we were told by staff that if a patient needed an interpreter then this could be arranged.

We were told by staff that they were able to care for patients with learning disabilities or living with dementia. Staff had access to linked nurses and specialist teams if they needed further advice or support. Dementia support nurses were seen on the wards and they wore a distinctive green polo shirt to help distinguish them from other staff members. During our inspection we did not observe staff caring for these patient groups however we were told how staff would use side rooms if possible to reduce distress and liaise with the patient’s carer on how best to look after the
individual. On Bartlett and St Cross wards we were told that dementia patients were identified by sunflower stickers at the top of their beds and they would have ‘This is me’ booklets in their medical notes. The surgical wards also told us they supported the John’s Campaign which enabled carers to continue caring for their loved ones throughout their hospital stay should they wish to, the carers would be given badges and had 24-hour access to the wards. However, we were told by staff on the surgical wards that it could be challenging looking after dementia patients in a busy surgical environment.

We were told that patients could be tagged on the electronic patient record system. This allowed staff to identify patients that might require additional support or need support communicating.

The pre-assessment unit did not carry out all the screening procedures in the unit, for example blood samples were taken in a different department in the hospital. This meant patients visits could be longer than necessary as they had to visit several areas to complete their pre-assessment tests. We were also told by patients in the pre-assessment unit that it was difficult to find the department due to inadequate signage directing them to the unit.

Access and flow

Trust wide

Referral to treatment (percentage within 18 weeks) - admitted performance

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to or above the England average. In the latest period, February 2018 68% of this group of patients were treated within 18 weeks versus the England average of 67%.

(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, two specialties, general surgery and trauma and orthopaedics were above the England average and one specialty, ENT, was below the England average. Cardiothoracic and neurosurgery were not carried out at this trust.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>82.2%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>69.2%</td>
<td>61.4%</td>
</tr>
<tr>
<td>ENT</td>
<td>59.2%</td>
<td>64.0%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>0.0%</td>
<td>82.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.0%</td>
<td>71.2%</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 has 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.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Hampshire Hospitals NHS Foundation Trust

Over the two years, the percentage of cancelled operations at the trust showed an upward trend, spiking between July 2017 and September 2017 where this trust cancelled 62 surgeries. Of the 62 cancellations 13% weren’t treated within 28 days.

The latest quarter from October 2017 to December 2017 has seen performance return to roughly the levels before the spike in the previous quarter and was lower than the England average where this trust cancelled 73 surgeries. Of the 73 cancellations 4% weren’t treated within 28 days.

Cancelled Operations as a percentage of elective admissions - Hampshire Hospitals NHS Foundation Trust
Over the two years, the percentage of cancelled operations at the trust was below the England average and followed a similar pattern. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Andover War Memorial Hospital

Referral to treatment time and cancelled operations were reported to us as trust-wide data rather than splitting into data for each hospital.

The day surgery unit was under-used. Data from the trust showed that less than 50% of the available capacity was being used between June 2017 and May 2018. Theatre 1 usage varied between 31%-46%. During the same period in theatre 2 usage was between 31%-54%.

Findings from our last report in 2015 showed that utilisation for theatre 1 was 40-48% and 27-36% for theatre 2. This showed there had been a slight drop in utilisation for theatre 1 whilst theatre 2 utilisation had remained similar.

Basingstoke and North Hampshire Hospital

Referral to treatment time and cancelled operations were reported to us as trust-wide data rather than splitting into data for each hospital.

Patients accessed the hospital through planned admissions (elective surgery) or via the emergency department (emergency surgery). For elective surgery we were told by staff that their pre-assessment appointment was usually six to eight weeks before the operation. More minor operations are seen in the Diagnostic Treatment Centre (DTC) and the Eye Day Care unit and patients were seen as day cases. For elective surgery patients were admitted directly to the relevant wards where they would be checked in and assessed for surgery.

Post-operative patients would remain in the theatre recovery unit until they were assessed as able to be transferred back to the wards or discharge home in the case of day surgery patients.

We were told by staff working in the recovery area that the level 2 patients would be cared for in the recovery ward after surgery before they were transferred to the critical care unit. Whilst level 3 patients would be transferred directly to the critical care unit after surgery.

When we talked with staff during the inspection we were told of the ways the hospital was trying to improve access and flow through the patient’s surgical journey.

Staff in the pre-assessment unit told us they were looking at ways to improve patient cancellation rates for example phoning patients in advance to confirm attendance.

The patient discharge planning process commenced as soon as patients were admitted. However, we were told by staff on the wards that discharges could be delayed. Staff told us they could be waiting anything from one hour up to a whole day for pharmacy to supply the medications needed by patients to take home (TTO medications). The trust had recently opened Overton ward which was a step-down ward. Medically fit patients who no longer required the high level acute ward care, but who were waiting for their care packages to be put in place, could be moved there. Elderly patients could also be moved to E2 the elderly rehabilitation unit. We were told by staff working on the surgical wards it was not always practical to transfer patients requiring physiotherapy to these wards. Staff were under the impression only occupational therapists were
attached to the wards and not physiotherapists. However, information supplied by the trust told us that physiotherapy support was available on these wards.

There was a hospital discharge planning team and they would help the wards with more complex discharges. Some wards had a discharge link nurse whose job it was to co-ordinate with this team to help speed the discharge process.

The therapy team working on D4 told us they pre-ordered the patient’s equipment needed after surgery as there was a 24 to 48-hour turnaround. This helped speed up patient’s recovery and discharge as the equipment was immediately available after their surgery.

We were told by nursing staff that pharmacy used to provide patients with medicines in monitored dosage systems (MDS) when they were discharged. However, nursing staff told us this service was no longer available and nurses had to arrange MDS supplies with local community pharmacies which could delay discharge.

We were told by staff working on C2 the pseudomyxoma specialist ward that emergency and elective operations were capped at five per week. If they had to go above five it would be the elective patients that would be cancelled not these patients.

When we talked with surgeons working in the division we were told that operations could be cancelled for a number of reasons, for example lack of equipment, with MRI capacity and template biopsy equipment not available. Other reasons were last-minute patient cancellations and due to staff sickness or unavailability. Cancer surgery would be prioritised over other surgeries to keep their cancellation rates down.

We were told that the trust used the ‘golden patient’ idea. The golden patient is a pre-selected first patient on the following day’s surgical list who is medically fit with a clear surgical plan. In audits by other hospitals it has been shown to improve operation start times and help meet clinical targets.

We asked staff working in the surgical division if they had medical outliers in their wards or recovery areas. A medical outlier is when a patient is not placed in the appropriate area. The main theatre recovery staff informed us that medical outliers were never put into the recovery area no matter how busy the hospital got. There were currently three medical outliers on C3 ward at the time of our inspection. Senior nursing staff in the DTC told us they currently had no medical outliers on their short stay recovery ward but usually they would have two or three. Normally they would be sent appropriate medical outliers i.e. patients without infection but occasionally they would be sent inappropriate patients. They found patients living with dementia medical outliers particularly hard to manage as the ward was not dementia friendly. We were also told during the winter pressures that 12 of their 16 patients were medical outliers which had put pressure on the staff. They had managed during this time and were proud that no surgical patients had been cancelled.

During the inspection we saw bed managers in the departments discussing moving patients with senior nursing staff to free up space for other patients. Although thought and understanding for patients involved in these moves was voiced, patients were moved for non-clinical reasons and this could involve moving several patients so mix-sexed breaches did not occur.

The trust supplied us with data from the surgical wards, breaking down the number of patients that had been moved to a different ward during their time in hospital, this did not include internal moves within wards. Between March 2017 – February 2018, 8747 patients were not moved, 1042 were moved once, 182 patients were moved twice, 40 patients were moved three times and 17 patients were moved four times. Patients were also moved at night (between 10pm – 6am). Between March 2017 – February 2018, 347 patients moved wards at night, which was not good for
continuity care and is known to cause confusion in the elderly. The trust recognised that this was a problem and had put a plan in place in 2017 to reduce the number of out of hours bed moves. Audits carried out by the trust in July 2017 and January 2018 showed that they had not achieved their targets and further measures were needed to be put in place to further improve.

Royal Hampshire County Hospital

Referral to treatment time and cancelled operations were reported to us as trust-wide data rather than splitting into data for each hospital.

Patients accessed the hospital through planned admissions (elective surgery) or via the emergency department (emergency surgery). For elective surgery we were told by staff that their pre-assessment appointment is usually six to eight weeks before the operation. More minor operations are seen in the Treatment Centre / Short Stay Surgical unit (SSSU) and patients were seen as day cases. For elective surgery patients were admitted directly to the relevant wards where they would be checked in and assessed for surgery.

Post-operation patients would remain in the theatre recovery unit until they were assessed as able to be transferred back to the wards or into critical care or discharge home in the case of day surgery patients.

Senior nursing staff on Wainwright ward told us the new surgical assessment unit on Kemp Welch ward was working well and improving the patient’s journey, for example, rather than having to wait in the Emergency Department (ED), patients could be transferred to the assessment unit where they were in a place of comfort with the appropriate staff looking after them rather than waiting in a busy ED on a trolley.

The patient discharge planning process commenced as soon as patients were admitted. However, we were told by staff on the wards that discharges could be delayed. Staff told us patients could be kept waiting for pharmacy to supply the medications needed by patients to take home (TTO medications). Senior nursing staff on Bartlett ward told us that delayed discharges were due to social reasons, either waiting for care packages to be put in place, trying to find rehabilitation beds or trying to find appropriate and affordable care homes places for patients to move to. Bartlett ward currently had two patients medically fit and who had been ready for discharge over the 33 days target, 63 and 74 days respectively.

We were told by nursing staff that pharmacy used to provide patients with medicines in monitored dosage systems (MDS) when they were discharged. However, this no longer happened and nurses had to arrange MDS supplies with local community pharmacies which can delay discharge.

Nursing staff in the Treatment centre /SSSU told us there was increasing number and demand in the unit with up to 80 patients a day. They were finding it challenging to manage that capacity and the flow of patients round the unit especially as patients were delayed being discharged due to waiting for results or discharge summaries. We were told that two of the bays on the SSSU were used as a patient overflow for the emergency department. We were told this was less than ideal and could block beds as patients were sometimes on the unit for a week. They had raised this issue but found there to be a lack of understanding from management.

Staff in the pre-assessment unit told us that there was a centralised administration team that made the bookings for them which worked well. Senior staff on the pre-assessment unit told us that sometimes the unit acted as overflow for the surgery day treatment centre.
When we talked with surgeons working in the division we were told that operations could be cancelled for many reasons for example lack of equipment, with MRI capacity and template biopsy equipment not available. Other reasons were last-minute patient cancellations and due to staff sickness or unavailability. Cancer surgery would be prioritised over other surgeries to keep their cancellation rates down. During our inspection we spoke to two patients who had their elective surgery cancelled by the hospital, with one patient telling us he thought it was due to winter pressures the hospital was under in December 2017.

We were told that the trust used the ‘golden patient’ idea. The golden patient is a pre-selected first patient on the following day’s surgical list who is medically fit with a clear surgical plan. In audits by other hospitals it has been shown to improve operation start times and help meet clinical targets.

We asked staff working in the surgical division if they had medical outliers in their wards or recovery areas. A medical outlier is when a patient is not placed in the appropriate area. Senior nursing staff on Wainwright ward told us that medical outliers were not usually placed on Wainwright ward, they usually went to Kemp Welch ward. Medical outliers usually arrived on the ward later in the day which staff said was a problem when a patient became unwell there was no one from the medical team on the ward at that time to help.

We were told that during the winter pressures there had been 10 medical outliers on the ward. Staff said having to manage many medical outliers on a surgical ward was not good for staff morale. We were also told by staff on St Cross ward that medical outliers sometimes became stranded on the surgical wards if they were in hospital for an extended period. This had led to elective surgery cancellations, as there was a reduced bed capacity on the ward.

We attended a bed meeting during this inspection and heard there were currently five medical outliers on Kemp Welch general surgery ward.

During the inspection we saw bed managers on St Cross ward discussing moving patients with senior nursing staff to free up space for another patient. One of the two registered nurses working on the ward, was then busy sorting out moving and getting rooms ready for the patients move that were taking place. We saw this had a direct impact on patient care as a patient on the ward was wanting for his pain medication. One of the patient being moved was a patient living with dementia who had been moved onto St Cross ward the day previously from a different ward. The trust supplied us with data from the surgical wards, breaking down the number of patients that had been moved to a different ward during their time in hospital, this did not include internal moves within wards as patients were moved several times into different rooms and bays to create capacity and compliance with mixed sex breaches. Between March 2017 – February 2018, 8352 patients were not moved, 831 were moved once, 145 patients were moved twice, 45 patients were moved three times and 21 patients were moved four times. Patients were also moved at night (between 10pm – 6am). Between March 2017 – February 2018, 419 patients moved wards at night, which was not good for continuity care and is known to cause confusion in the elderly. The trust recognised that this was a problem and had put a plan in place in 2017 to reduce the number of out of hours bed moves. Audits carried out by the trust in July 2017 and January 2018 showed that they had not achieved their targets and further measures were needed to be put in place to further improve.

**Learning from complaints and concerns**

**Summary of complaints**

From March 2017 to February 2018 there were 99 complaints about surgical care. The trust took
an average of 34.7 days to investigate and close complaints. This is in not in line with their complaints policy, which states complaints should be completed within 25 days.

The most prevalent complaint themes were clinical treatment with 32 (32.3%), patient care with 21 (21.2%) and communication with 15 complaints (15.2%).

Basingstoke and North Hampshire Hospital had the most complaints about surgical care with 49 (49.5%), followed by Royal Hampshire County Hospital with 48 (48.5%) and Andover War Memorial Hospital with two complaints (2%).

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

**Andover War Memorial Hospital**

The service treated concerns and complaints seriously and investigated them. However, the trust did not respond to complaints in a timely manner.

Staff in the day surgery unit 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 and became formal complaints. Conflict resolution training was part of the trust’s mandatory training. If the problem could not be resolved by the team or the complainant wanted to speak to someone more independent, staff told us patients would be given contact details of the trust’s customer care team who provided the Patient Advice and Liaison Service (PALS) who offered help, advice, support and potential resolution to those wishing to make a complaint. The customer care team had no office at the Andover War memorial hospital.

We saw that there were posters, which explained and gave details of the way patients could make complaints. This included information on how to obtain independent advice from advocacy services and details on the Health Service Ombudsman.

Patients could also find information on how to make a complaint on the trust’s website under the patients and visitors section.

Staff told us feedback from complaints and concerns were discussed during daily staff catch ups and in handover sessions. However, we were not assured how information was disseminated from senior staff members to the team in the day surgery unit.

The operational service manager and clinical matron were responsible for ensuring all complaints relating to the day surgery unit were thoroughly investigated, for the appropriate and timely response to complaints raised and that resulting action plans were implemented in the unit and learning shared amongst the team.

**Basingstoke and North Hampshire Hospital**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which was shared with staff. However, the trust did not respond to complaints in a timely manner.

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Staff told us feedback from complaints and concerns were discussed in various ways by different wards and departments this included via email, in ward and team meetings, during daily face to face staff catch ups, huddles and in handover sessions. We saw evidence of this in minutes from the ward’s monthly meetings.

The operational service managers and clinical matrons were responsible for ensuring all complaints relating to the surgery division were thoroughly investigated, for the appropriate and timely response to complaints raised and that resulting action plans were implemented in the division and learning shared amongst the surgical teams.

Royal Hampshire County Hospital

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The operational service managers and clinical matrons were responsible for ensuring all complaints relating to the surgery division were thoroughly investigated, for the appropriate and timely response to complaints raised and that resulting action plans were implemented in the division and learning shared amongst the surgical teams.
Is the service well-led?

Leadership

Trust wide

The trust was divided into three service groups, Medical Services, Surgical Services, Family and Clinical Support Services. Each service had a director and a management structure in place with clear lines of responsibility and accountability.

There was one trust-wide surgical services management team that worked across the three sites. The surgical service was formed of six areas with a clinical director heading up each area, surgery, head and neck, peritoneal malignancy, trauma and orthopaedics, cancer services and critical care and anaesthetics. Each clinical director was supported by an operational service manager (OSMs).

Whilst on inspection we met with clinical directors and OSMs from each of the groups to gain an understanding of the local leadership in each of the areas. We reviewed minutes of meetings, risk registers and reports to gain an understanding of the issues.

Senior management staff working in the surgical services mainly divided their time between the Basingstoke and Winchester sites with an office at each location. No senior surgical service staff were based at the Andover site and there seemed to be no formal arrangement as to how often they visited the services based at Andover War Memorial Hospital.

At a more local level, surgical wards and departments were run by clinical matrons and senior sisters.

Clinical matrons from all three service groups met once a month for an all-day meeting and this day had been nicknamed ‘matron school’ by the clinical matrons. This was a formal meeting overseen by the chief nurse which provided a platform to discuss governance, risks, performance issues and to share learning amongst the group and have a cohesive approach to running their wards and departments. We were told by the clinical matrons we spoke with that this was a valuable day. It was up to the individual matrons to decide how to disseminate information gained from this day down to their teams.

Andover War Memorial Hospital

There were three clinical matrons working at the Andover hospital site, however, the day surgery unit did not come under their remit. We met with the clinical matrons during our inspection and they said although they did not know the intricacies of the unit they were on hand if staff needed help or support. The clinical matron responsible for the unit was based at the Winchester site. The unit was run day to day by a senior sister who provided clinical support to the team. It was unclear how often the clinical matron visited the day surgery unit.

Although the team worked well together and were focused on providing treatment and care to patients, we were not assured that there was a robust management system in place, with senior managers having oversight of the service. There was a disconnect with the wider trust and staff that worked for Andover hospital.

Basingstoke and North Hampshire Hospital
Each surgical ward was managed by a clinical matron with support from senior nurses, they worked alongside other clinical staff. C3 ward currently had no clinical matron therefore the clinical matron from C4 ward was overseeing both wards. The pre-assessment unit had recently changed groups and was now in the critical care and anaesthetics group and would be managed by the Diagnostic Treatment Centre (DTC) clinical matron.

The majority of staff we spoke with felt their clinical matrons were visible and felt supported by them. However, we did find evidence that there were issues with cultural problems and management of inappropriate behaviour and this was seen from the staff survey results.

Nursing staff and allied health professionals said that consultants and medical staff were approachable and supportive. We saw good interactions between all grades and roles of staff on our inspection.

We were told by band 6 nurses that they had been on the in-house 6 leadership course and that it was a worthwhile course and a good development opportunity.

Royal Hampshire County Hospital

Each surgical ward was managed by a clinical matron with support from senior nurses, they worked alongside other clinical staff. The pre-assessment unit was managed by the St Cross ward clinical matron but run day to day by a senior band 7 nurse. It was unclear how often the clinical matron visited the unit but the senior sister felt they were able to phone their clinical matron if support was needed.

The majority of staff we spoke with felt their clinical matrons were visible and felt supported by them.

Nursing staff and allied health professionals said that consultants and medical staff were approachable and supportive. We saw good interactions between all grades and roles of staff on our inspection.

Vision and strategy

When the Hampshire Hospital Foundation Trust was established in 2012 part of its strategic plan was to build a new Critical Treatment Hospital plus a Cancer Centre. It was part of the hospital’s integral plan to tackle the growing demands for patient care in the region. However, it was decided in November 2017 by healthcare’s governing bodies not to take these plans forward.

In light of this decision the surgical services senior team were now working on a strategic plan on how to provide surgical care for non-elective patients without impacting on the trust’s elective work. These plans were still in the draft stage during our inspection. Senior surgical management staff we spoke with during this inspection discussed ideas of how the surgical services could be developed and improved in the future, how best to use all three sites and improve theatre utilisation. However, these were very much innovated ideas rather than actual strategic plans.

The trust’s vision was to provide ‘outstanding care for every patient’ this was underpinned by four strategic objectives; providing outstanding care to every patient; empowered staff; living within our money and innovating for the future. The trust had a set of operational deliverables for 2018/19 which was going to support their delivery of the strategic objectives which had been developed with engagement with staff, governors, stakeholders and the board.
Staff from all three sites knew how their work contributed to the wider vision of the trust and they were aware of the trust values of CARE; Compassion - caring about our patients and our colleagues; Accountable and responsible, always improving; Respect for all – colleagues, patients and their families and Encouraging and challenging each other to always do our best.

**Andover War Memorial Hospital**

Staff we spoke with at Andover hospital were proud of the service they provided to patients. They were unaware of whether there would be any changes to the services they provided in the future but hoped that the day surgery unit would remain at Andover as they felt patients were happy with the services that they provided. They had no vision or strategy for the development of the service.

The trust values were displayed in the patients’ waiting room.

**Basingstoke and North Hampshire Hospital**

Staff we spoke with at a more local level were passionate about the care and treatment they wanted to provide for their patients. They wanted to put patients at the centre of what they did. However, they were concerned with how the cost improvement program and staff shortages would impact on their ability to do their job effectively and without impacting on patients.

We were not told about vision or strategy plans for the individual departments or speciality surgical groups.

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**Culture**

Managers across the trust tried to promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

**Andover War Memorial Hospital**

Staff we spoke with felt supported, respected and valued in their working environments. Staff confirmed that they felt able to be open and transparent, reporting adverse events and incidents.

Staff spoke positively and passionately about the service meeting the needs of the local patients and the surrounding areas. Staff commented on the fact that the service might seem old-fashioned but patients loved it.

Staff valued the WOW awards and DONA awards, where teams and individuals were acknowledged for their care, commitment and compassion they had shown. The day surgery unit displayed certificates for any nominations and awards they had won.
As per NHS guidelines the trust had appointed a Freedom to Speak Up Guardian with whom staff could talk to in confidence if they had concerns. We were not told if the Andover site had a freedom to speak up guardian or representative on site.

The surgical services group had not scored well in certain areas of the staff survey. These included senior managers not involving staff in important issues, how senior managers acted on feedback, the appraisal process and if staff felt they were valued. The surgical services group had decided to focus on three key areas of communication, manager’s skill and staff morale and had developed an action plan to help address the issues in these areas.

Basingstoke and North Hampshire Hospital

Staff we spoke with felt supported, respected and valued in their working environments. Staff told us they felt able to be open and transparent, reporting adverse events and incidents in a way which helped improve things within the service. Senior staff told us they promoted an ‘open door’ and a ‘no blame’ culture in the teams.

However, trust wide feedback from various staff groups and whistle-blowers who contacted us confidentially during our inspection raised concerns that there was a culture of bullying and harassment. The trust had recognised they needed to address the bullying culture.

As per NHS guidelines the trust had appointed a Freedom to Speak Up Guardian with whom staff could talk to in confidence if they had concerns. There were still some worries amongst staff how this scheme actually worked and how confidential it really was.

Most of the staff we spoke with on this inspection felt there was good teamwork amongst their colleagues. Although, they felt that staff shortages could sometimes make work challenging.

Staff in the main theatres told us they had worked together for many years and they had great morale and felt appreciated by their manager.

Staff valued the WOW awards and DONA awards, where teams and individuals were acknowledged for their care, commitment and compassion they had shown. Wards and departments throughout the surgical service displayed certificates for any nominations and awards they had won.

We were told that although cross hospital working was encouraged with theatre staff this was not always possible or practical, as staff tended to work in speciality teams, it could take an hour to drive between sites and staff tended to have lead roles outside their theatre work which would be hard to fulfil if they were moving around hospitals frequently.

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Most of the staff we spoke with on this inspection felt there was good teamwork amongst their colleagues. Although, they felt that staff shortages could sometimes make work challenging. Many ward staff said their matrons were encouraging and worked hard to keep morale high amongst staff.

Staff valued the WOW awards and DONA awards, where teams and individuals were acknowledged for their care, commitment, and compassion. Wards and departments throughout the surgical service displayed certificates for any nominations and awards they had won.

We were told that although cross-hospital working was encouraged with theatre staff, this was not always possible or practical, as staff tended to work in speciality teams, it could take an hour to drive between sites and staff tended to have lead roles outside their theatre work which would be hard to fulfil if they were moving around hospitals frequently. We were told by a consultant that worked across all three sites that culture and working practices were not the same at each of the sites. This made cross-site working challenging at times for them.

The surgical services group had not scored well in certain areas of the staff survey. These included senior managers not involving staff in important issues, how senior managers acted on feedback, the appraisal process, and if staff felt they were valued. The surgical services group had decided to focus on three key areas of communication, manager’s skill, and staff morale and had developed an action plan to help address the issues in these areas.

**Governance**

The trust had an approach to continually improve the quality of its services but were not assured of its effectiveness to keep patients safe. There were gaps in some of its governance processes including in management of mixed-sexed breaches.

Surgical services held monthly governance meetings. Each of the six surgical areas was represented by the clinical director and the operational service manager (OSM). Clinical matrons were not included on the surgical management team structure chart and were not routinely invited to the monthly governance meetings.

We reviewed three months of minutes from the governance meetings and found that they had a set agenda. In this meeting, new business plans and new policies for approval were discussed, quarterly reports were reviewed such as the infection control and medication incidents reports, and OSMs presented detailed performance information on their specific area. This information included: quality measures, such as complaints, patient out of hours bed moves and infection rates; finance measures; activity against planned activity; workforce measure such as sickness rate and appraisals completion rate; and recovery plans.

During our inspection, we saw the close working relationships between the clinical directors and the OSMs but it was unclear how the OSMs and clinical matrons worked together. As no clinical
matrons attended the monthly governance meetings it was unclear how information disseminated
down to ward level and we were not informed or shown evidence of meetings between the clinical
matrons and the OSMs.

We were also unclear if separate specialities had they own meetings where senior staff could
discuss more local issues or if this happened informally in the teams.

We were told by the director of surgical services there were weekly morbidity and mortality
meetings in the clinical areas. Teams had their own format for these meetings but the director of
surgical services hoped to bring in a more standardised system across the teams.

Andover War Memorial Hospital
From the surgical services board meeting information from the day surgery unit was presented in
with theatre data from the Royal Hampshire County Hospital, they were not seen as an individual
service.

At a ward level there were no discussions about key performance indicators and governance
parameters. It was unclear to us when we inspected how governance worked in the day surgery
unit. It was reported in the 2015 CQC report there was a disconnect between the day surgery unit
and the wider trust and we found this still to be the case.

Basingstoke and North Hampshire Hospital
Surgical wards and departments had monthly meetings. We reviewed three sets of notes from C4,
D1, D4 wards and the DTC. From these minutes we could see that the clinical areas were
discussing incidents and complaints, appraisal and mandatory training, friends and family data,
results for delayed discharge, ward issues and audit results.

Royal Hampshire County Hospital
There were no formal monthly meetings for the surgical wards and departments.

We were told there was a theatre management group which met monthly. Staff also told us about
a weekly meeting held for all theatre staff, called ‘the big room meeting’. In this meeting staff could
voice their concerns and bring useful information to the team that could aid learning. We were told
that staff found this was an excellent forum and the meeting was well attended every week.

Management of risk, issues and performance

Trust wide
The trust had systems for identifying risks and issues and monitoring performance. However, there
was inconsistency in linking this information effectively into improving the services.

There was a risk register for the surgical service group this looked at risks across all three hospital
sites. Risks were identified and reviewed quarterly, in accordance with the trust’s Risk
Management Framework 2016.

Risks were split into two different types, business unit risks and divisional risks. Where business
unit risks were similar, i.e. staff shortages in individual sites and individual wards, the risks would
be amalgamated on the divisional risk register.
The surgical service group had reviewed and updated the business unit and divisional risk register during April 2018. There were currently 236 business unit risks on the trust’s reporting system and 22 identified risks on the divisional risk register. Of these risks, three had a current risk rating of 15 or above (red rating); nine had a current risk rating between eight and 12 (amber rating). Red rated risks included insufficient money to replace damage/faulty equipment, failure to deliver financial targets and the inability to recruit required staffing levels.

The risk register did not include dates risks were added to the risk register or dates when action plans needed to be reviewed. This made it difficult to assess if risks were reviewed regularly.

The trust board monitored the surgical care group’s performance via a dashboard such as compliance with access targets in cancer and 18 weeks refer to treatment targets (RTT).

**Andover War Memorial Hospital**

Staff we spoke with on the Andover site and senior managers for the surgical day unit were not aware of risks to the service.

It was unclear how the surgical day unit identified risk. There was no regular formal process to discuss and manage risk, issues and performance between staff at Andover and senior managers.

**Basingstoke and North Hampshire Hospital**

Senior staff and staff on the surgical wards and departments on the Basingstoke site could tell us about the current risks to the service. However, it was unclear how risks were identified within the surgical group and how they were raised higher. We saw little evidence of risks being discussed in ward meetings, service meetings and at the surgery divisional board meeting.

**Royal Hampshire County Hospital**

Senior staff and staff on the surgical wards and departments on the Winchester site could tell us about the current risks to the service. However, it was unclear how risks were identified within the surgical group and how they were raised higher. We saw little evidence of risks being discussed in ward meetings, service meetings and at the surgery divisional board meeting.

**Information management**

**Trust wide**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust used computer toolkits and dashboards to collect and monitor the surgical services operational performance in national, commissioning and internal targets. Data on staffing, quality and safety was collected and reviewed at board meetings.

The trust had a monthly data quality group which monitored data quality across the trust.

The trust had appointed a Chief Clinical Information Officer & Chief Nursing Information Officer in 2017. Their role was to lead on the digitalisation programme ensuring that the trust’s investment in IT was useful to patients and clinicians.
The trust had plans to move towards a paperless single electronic version of patient records and to electronic capture patient information directly at the point of patient care. The idea being the electronic patient record would capture the patient journey from referral through to discharge. The trust gave no timeline when they would like these systems to come to realisation.

A computer system was used to track patients through their surgical journey on the day of their surgery. However, at present the surgical service division did not use a management computer system, to book patients in for surgery, to timetable the theatres, allocate staff and to help with the management of theatre lists.

The trust had a webpage where the public could access much information about the hospital, including information about the trust, all three sites, theatre and ward information, patient and visitor's information, how to make complaints and compliments and the latest hospital news.

**Andover War Memorial Hospital**

Information from the day surgery unit was mainly amalgamated with information from the Royal Hampshire County hospital. However, it was unclear how much information was collected from the Andover site to monitor its services.

**Basingstoke and North Hampshire Hospital**

The operational service managers were responsible for the collection and monitoring of performance indicators and to use this information to improve the quality of the service. It was their responsibility to disseminate this information round their individual surgical teams and up to the surgery divisional services management team. We were assured of the process to report up but not assured of the reporting process to individual surgical teams.

**Royal Hampshire County Hospital**

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**Engagement**

**Trust wide**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Patients were encouraged to complete regular surveys to provide feedback on the care they had received. Themes of concerns and complaints and feedback from the ‘friends and family test' survey was reviewed regularly.

The trust had a staff engagement plan with detailed actions that followed on from the staff survey and included action to improve staff wellbeing and the culture.
The trust took part in PLACE (Patient-led assessment of care environment) assessments. They were annual appraisals involving local people called patient assessors who go into hospitals to assess how the environment supports the provision of care. Areas looked at include cleanliness, food and hydration, privacy, dignity and wellbeing, condition appearance and maintenance, dementia, and disability. We asked the trust to provide us with PLACE results for the surgical wards for 2016 and 2017. However, we only received information relating to the area of cleanliness for some of the surgical wards at the Basingstoke and Winchester sites.

In the last national NHS staff survey published in 2017 the trust had a response rate of 43%. The surgical services group had developed an action plan to address the areas where they had scored poorly in the survey. This included ways to communicate better, improve managers skills and improve staff morale. The trust also conducted more local staff surveys as part of its quarterly staff friends and family test (FFT). The top concern for the trust was the deviation between the percentage of respondents who would recommend the trust as a place to be cared and treated compared with those who would recommend the trust as a place to work (a lower percentage). Other themes that were seen from the FFT was staff parking issues, staffing levels, pay and prospects and how staff were treated, with allegations of bullying, concerns about leaders not taken seriously and unable to speak up. The trust had devised an action plan to address issues outlined in these reports.

The trust produced a monthly newsletter, called PULSE, to update staff on current and future plans, this was emailed to all staff.

Andover War Memorial Hospital

To apply for JAG accreditation, which is the formal recognition that an endoscopy service (reported in the CQC medical care report) had demonstrated that the service had the competence to deliver against the criteria set out in the Joint Advisory Group gastrointestinal endoscopy standards, the day surgery unit had to complete patient satisfaction surveys. The results from these patient surveys were displayed on notice boards outside the patient’s waiting room.

Basingstoke and North Hampshire Hospital

The hospital had engaged in an open day. Approximately 800 visitors visited the hospital to get a ‘behind the scenes’ tour, partake in interactive displays and meet the staff. We were told by staff in the Diagnostic Treatment Centre (DTC) that visitors had been able to look round their ward and operating theatres and try out surgical equipment.

Royal Hampshire County Hospital

We were told by staff about training days that had been sponsored by external companies and changes made to the surgical wards and working practices after engagement and feedback from patients and their families.

Learning, continuous improvement and innovation

Trust wide

The trust was committed to improving services by learning from when things went well and when they went wrong.
The trust had a quality improvement strategy 2018-2020 with the tagline ‘everyone is an improver’, the strategy aimed to empower all staff to get involved in projects to improve patient care.

The trust and surgical services internal and external audit program highlighted areas for improvement and action plans put in place to address issues and raise standards of the service.

Senior surgical management staff we spoke with during this inspection had many ideas of how the surgical services could be developed and improved in the future, how best to use all three sites and improve theatre utilisation. However, these were very much innovated ideas rather than actual strategic plans.

The trust ran twice yearly Return to Practice Programmes in conjunction with Southampton university, for nursing, allied health professional and healthcare scientists staff. This gave staff, who had taken a break from these careers, a way to update their skills and return to the field. The trust saw this as an effective way to recruit trained staff.

The trust had introduced Schwartz rounds where staff from all backgrounds came together to discuss specific topics about providing patient care and to reflect on the emotional aspects of their roles.

The trust was currently not planning on investing in any robotics services. We were told by senior surgical staff they would like to set up a virtual fracture clinic.

**Andover War Memorial Hospital**

During the inspection senior surgical staff discussed ideas they had to make better utilisation of the day surgery unit, however there were no current plans to improve the service.

**Basingstoke and North Hampshire Hospital**

The trust is one of only two designated specialist treatment centres in the country for the treatment of Pseudomyxoma. This is an extremely rare condition that usually develops from cancers of the appendix. The diverse multidisciplinary team had developed the skills to help patients through the extensive treatment and share their knowledge on international courses and conferences.

During the inspection we met inspirational staff and teams that strove to make their services better. These could be big projects like the urology prostrate cancer trial that led to significant changes in practices. Or more practical day to day solutions, like the clinical matron in the Diagnostic Treatment Centre who found ways to develop and rotate staff to create a more effective and efficient way of working. This had improved the patient’s pathway and used staff more efficiently.

Whilst staff were committed to providing high quality care they did not have strategic plans to implement service developments.

**Royal Hampshire County Hospital**

During the inspection we met inspirational staff and teams that strove to make their services better. We were told how the clinical matron on Kemp Welch ward had redeployed her resources to create a ward clerk post which helped with the smooth running of the ward and freed up clinical staff to spend more time with patients. We were told about how the theatre teams ‘big room’ meeting was encouraging staff to come up with ideas to make the service better for patients and staff alike.
Whilst staff were committed to providing high quality care they did not have strategic plans to implement service developments.