Portsmouth Hospitals NHS Trust

Evidence appendix

Trust Headquarters, F Level
Queen Alexandra Hospital
Portsmouth
Hampshire
PO6 3LY

Tel: 02392286000
www.porthosp.nhs.uk

Date of inspection visit:
15 to 17 October 2019 and
12 to 14 November 2019

Date of publication:
29 January 2020

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

<table>
<thead>
<tr>
<th>Site name</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Alexandra Hospital</td>
<td>Southwick Hill, Cosham PO6 3LY</td>
<td>Emergency department, cancer centre, renal service, renal transplantation service, maternity, gynaecology, Wessex kidney centre, gastroenterology and hepatology service, Solent bowel screening services and dedicated alcohol service, specialist rehab ward for working age patients, hyper acute stroke unit, diabetes and endocrinology diagnostics and treatment, general surgery, upper and lower gastrointestinal surgery, urology, bariatrics, vascular, plastics and general paediatrics surgical services.</td>
<td>Portsmouth and South East Hampshire</td>
</tr>
</tbody>
</table>
Gosport War Memorial Hospital
Bury Road, Gosport, PO12 3PW
Minor injury unit, endoscopy suite, medical photography, outpatients clinics, diagnostic imaging, phlebotomy.
Hampshire and West Sussex

Fareham Community Hospital
Brook Lane, Sarisbury Green, Fareham, Hampshire, SO31 7DQ
Clinical photography, diagnostic imaging, phlebotomy.
Portsmouth, Fareham and Gosport, South Eastern Hampshire

Petersfield Community Hospital
Swan Street, Petersfield, Hampshire, GU32 3LB
Dietetic services, Grange maternity centre, clinical photography, phlebotomy, diagnostic imaging, outpatients clinics.
Portsmouth, Fareham and Gosport, South Eastern Hampshire

Saint Mary's Community Health Campus
Milton Road, Portsmouth, Hampshire, PO3 6AD
Day hospital incorporating falls and Parkinson’s clinics, dietetic services, clinical photography, occupational therapy, hip and knee clinic, phlebotomy, outpatients clinics, physiotherapy, Portsmouth enablement centre, Portsmouth maternity centre.
Portsmouth, Fareham and Gosport, South Eastern Hampshire

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

Is this organisation well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the trust faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Board Members

Leaders had the skills, knowledge, experience and integrity that they need – both when they were appointed and on an ongoing basis. The trust’s executive team was re-established between mid-2017 and mid-2018 when a completely new board (apart from Chief Financial Officer) was appointed. The board retained much the same membership until recently when three executive directors resigned, citing personal reasons for their departures. Despite the recent changes to the chief nurse, chief operating officer and chief financial officer, the board had demonstrated stable leadership.
The chief executive officer had been in post since 2017. He was a qualified nurse and has held senior director-level posts at a number of trusts including as chief operating officer, managing and executive director.

The chief nurse had been in post since June 2019. She had previously held a number of director-level nursing positions in large trusts, most recently at a hospital in another region where she was chief nurse from 2009-2019.

The medical director has been in post since 2017. He previously led the hospital’s critical care department and was an associate medical director.

The interim chief operating officer had been in post since September 2019. He previously held director-level positions, including as chief operating officer, at a number of NHS trusts.

The chief financial officer joined the team in July 2019. He had twenty years’ experience working in NHS financial roles and was most recently chief financial officer at another NHS trust.

The director of governance and risk was a solicitor, who was the nominated individual for the trust. She had worked in local government before joining the NHS in January 2018.

The director of strategy and performance was previously a delivery and improvement director for NHS Improvement (NHSI). She had also held posts as at NHS England, a PCT cluster and NHS London strategic health authority. She joined the trust in January 2018.

The workforce and organisational development director joined the organisation in October 2018. She had thirty years’ experience working in the public sector, including the role of director of human resources and corporate services.

The trust had seven non-executive members including the chair. They had a wide variety of skills and experience including legal, medical, financial, military, business, operations, public sector and leadership and had executive and non-executive board experience.

Each board member went through a rigorous recruitment process to verify they had the skills, knowledge and experience for the role. We reviewed five directors’ files and found the trust went through a fit and proper person checklist for each recruit which included the required fit and proper person checks, for instance, interviews, references and background checks. Each checklist was reviewed, dated and signed by the chair.

Reviews of the senior leadership team member’s fitness and performance, including executive and non-executive directors, were completed annually. The trust had a system to perform a fit and proper review and separate appraisal annually for each senior leader. We saw five files which showed there was an annual appraisal and fit and proper person review for each senior leader who had been in the trust for more than one year.

The board benefited from both the expertise and the fresh eye that different members brought to
the board. They used their background and expertise to inform the work that they did, working as a unitary board to provide support and challenge across committees and the board, regardless of whether matters were within their area of expertise.

The board reviewed their effectiveness and developed together as a team throughout the year. The team reflected internally and worked with a recognised external audit, consulting and advisory firm to review their leadership and governance structure and identify improvements. This had helped to develop improvements in structure, governance, and senior level job roles.

They had a board development program which provided a structured approach toward individual and team development. The program was designed with the external firm and board members. It was in line with the principles for good governance as set out in ‘The Healthy NHS Board 2013’ guide, NHS Leadership Academy. The program consisted of five bi-monthly development days each of which focussed on a specific, relevant topic, for instance risk management and cultural change and management. Board members reflected that the development days were valuable and that they welcomed continuous improvement.

None of the executive board members identified as Black and Minority Ethnic (BAME). Four of the executive board members were female.

Of the seven non-executive board members, one identified as being BAME. Three of the non-executive board members were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BAME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>57%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>14%</td>
<td>43%</td>
</tr>
<tr>
<td>All board members</td>
<td>7%</td>
<td>50%</td>
</tr>
</tbody>
</table>

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

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them.

As is the case in most NHS trusts, there were significant tensions between quality and sustainability in leading the trust to meet its commitments and vision within its means. The senior leadership team acknowledged and considered these issues throughout their processes. Balancing quality and sustainability was a thread throughout the board’s work. The leaders understood the challenges and they were a regular topic of discussion in meetings. We saw in board papers, committee meetings and board meetings that the efficiency and quality of services
were raised and discussed with regard to items on the agenda, for instance relating to winter pressures, new contracts, environmental redevelopment, corporate strategy and the Long Term Plan.

Issues concerning quality versus sustainability were raised by both executive and non-executive board members. In the board and committee meetings we observed we saw that, when questioned, board members were usually able to demonstrate how quality and sustainability had been reviewed and considered. In one instance, when the evidence was not to hand, the presenter stated that they knew the quality issue had been considered and they would revert to the group with the evidence. Board members were involved broadly in discussions both within their areas of expertise and outside.

To identify challenges to quality of care and actions to address them, the chief nurse was leading a project on compassionate care in support of the trust’s strategic aim to support safe, high quality and patient focussed care. The project considered how compassion could be measured and aimed to raise the profile of compassion in the organisation as well as create a compassion dashboard to highlight qualitative and quantities measures of care. The board had oversight of the project and its focus on compassionate care had board wide support.

Board members understood the risks related to non-clinical aspects of trust infrastructure. For instance, the leadership recognised both the current low level of digital maturity and the challenges with the current state of existing IT systems. These systems could be slow, difficult to use and were largely not interoperable or capable of integration into newer systems. In response to this risk, the trust had developed a comprehensive five year digital strategy to develop both the organisation’s digital maturity and replace or improve existing digital systems.

Leaders were visible and approachable. The leadership team aimed to reach out to staff members by being available in their workplace. The trust had monthly Working Together Days where the leadership team would engage with one to three departments on site. There were also trolley dashes where leaders would go to departments and wards to encourage staff engagement for instance with regard to the staff survey and anti-violence campaign.

Staff fed back that they felt leaders were visible and approachable. Staff we spoke to on the core service inspection generally felt that senior leaders were approachable. Staff across the trust cited times that members of the leadership team had visited their department or ward. Staff members noted that the CEO was a trained nurse and told us about times he had offered assistance while he was in their ward for instance by feeding a patient or pushing a trolley.

Staff generally reported that their immediate line managers were visible and approachable. However, they did report that they could receive differing levels of support depending on their line manager.
Executive and non-executive board members visited different areas of the trust regularly and were currently introducing a system where executive and non-executive board members would visit departments together as part of a program reaching across the hospital.

Specialist leadership was generally accessible across the trust. For instance, pharmacy leadership was visible at trust and ward level. The chief pharmacist was new in post and had implemented changes to encourage communication within the department and to increase the visibility of pharmacy staff and the service across the trust.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and there was a leadership strategy or development programme, however this did not include succession planning for the senior leadership team.

Objective four in the trust strategy Working Together stated, We will invest in the capability of our people to deliver on our vision. This directly spoke to supporting the priorities of ensuring sustainable, compassionate, inclusive and effective leadership. One element of the objective was that the trust would, ‘enhance management and leadership capability through mechanisms that support the identification, development and recognition of leaders’, the next addressed effective training and development to support succession planning.

The trust had rolled out a leadership development programme to the senior leaders and managers within the trust. The programme was a tailored development course aligned to the trust’s vision, values and three-year culture change programme. This programme aimed to train senior leaders to develop a compassionate and inclusive leadership approach to support the delivery of the trust strategy.

In addition, the ‘passport to manage’ curriculum supported progression and succession planning. This recognised management as a carer requiring continued education and training. Senior leaders we spoke with reported this was a valuable and useful programme.

However, while there was a programme to support succession at lower bands and plans for cover for the members of the executive team should they need short term cover, there was not a long term succession plan for the senior leadership team. The senior leadership team was aware of this issue. They were considering various projects to address this including a ‘shadow board’ which would give more junior management staff members the opportunity to experience board membership.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and a set of values, with quality and sustainability as top priorities. The trust had a straight forward set of four core values: “Working together for patients, with compassion, as one team, always improving”. The vision was “Working together to drive excellence in care for patients and communities”. The vision and values were the foundation of the trust’s strategy. Safety and quality were aligned with “working together for patients” while efficiency and living within their means aligned with “always improving”. Other primary focuses included “compassion” and “working as one team”.

The trust had a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. Since our last inspection the trust had implemented an overarching strategy, Working Together, which was based on trust vision, ‘Working together to drive excellence in care for our patients and communities.’ Senior leaders explained that the title of the strategy was important because of the engagement with staff to create and implement the strategy. The trust was focusing on leadership and culture, which was reflected in the strategy.

Working Together was underpinned by several supporting strategies which were created at a trust, divisional or departmental level. For instance, the Estates Strategy, Workforce and Organisational Development Strategy (2019 – 2023) and Digital Strategy (2019-2024). The trust also had clinical divisional strategies and issue specific strategies, such as an equality and diversity strategy and a dementia strategy, which aligned to Working Together, although not all divisions had strategies.

In the Workforce and Organisational Development Strategy (2019 – 2023) “Working Together to invest in our People” the trust outlined key outcomes and measures of success. This reflected a strategy which was not only aspirational and which had clear deliverables and expected outcomes. These objectives took account of national and local key drivers making reference to the NHS Long Term Plan, sustainability and transformation partnerships and workforce standards.

The recent “Workforce Report September 2019” reflected that the trust was already seeing a significant improvement on some of their workforce indicators. For instance, turnover was down from 13.5% to 11.6% (below the trust’s target of 12%), stability index rate was up at 85.5% (the trust’s target was 86%), vacancy rate was 7.3% (below the trust’s target of 7.5%), overall appraisal rates met the trust’s target of 85%. Recent data from the trust reflected further improvements, for instance improved levels of sickness absence at the trust and reduced agency use across some core services.
Additionally, Essential Skills Compliance was 95.5% (exceeding the trust target of 85%). This performance was boosted by e-learning compliance. However, the target for face-to-face training such as basic life support was improving, but not yet being met.

There was focus on the “Culture Change Programme’ with an emphasis on better staff engagement. Interviews with staff reflected the trust had engaged with staff in developing the trust strategy and other supporting strategies such as the Workforce Strategy.

The trust has implemented a comprehensive digital strategy in support of Working Together, which highlighted the importance of developing the trust’s IT systems and infrastructure. The digital strategy addressed issues including the digitisation of processes, workflows and care pathways, supporting emerging healthcare technologies with an aim to transform the way the trust worked, developing the organisation’s digital maturity and replacing or improving digital systems. The team recognised the importance of early user engagement and adoption of digital change, which was included in the strategy. There was a future plan to develop an information strategy to support the digital strategy.

The trust also had departmental and divisional strategies. For instance, the pharmacy team had a Medicines Optimisation Strategy which fit with national priorities and was linked to the trust’s overall vision. Current priorities included working towards a full seven day working plan and the set up and roll out of an electronic prescribing system (ePMS). The ePMS would allow real-time data on issues such as missed doses and support medicines optimisation in the trust. However, the trust did not yet have the funding for this system.

The vision, values and strategy were developed using a structured planning process in collaboration with staff and people who use services. The strategy was developed in three stages; first the team created a baseline report, they then used this report to engage with staff about what should be in the strategy, finally this feedback was reflected back into the final version of the strategy.

Staff reported they had the opportunity to engage with regard to the new trust strategies. The trust used outreach to staff to engage them in the process of drafting the strategy. Engagement included meetings and more bespoke engagement such as trolley dashes so that staff could provide input on the process easily, without leaving their work area. The first group of culture change agents were identified in this process and a patient and carer collaborative group fed into the document from the patient perspective.

The vision and values were fundamental to how the trust worked, staff knew and understood what the vision, values and strategy were, and their role in achieving them. On the core service inspection, staff could describe how they applied the trust values in their day-to-day work. We saw
posters displaying the trust values on noticeboards throughout the trust and heard staff referring to the values in particular being ‘one team’.

The strategy was aligned to local plans in the wider health and social care economy and have been planned to meet the needs of the relevant population. The intent and ambition of the system was reflected in the trust’s “Working Together” strategy that was launched in July of this last year (2018/19). One of the trust strategic objectives that had been developed was focused on the ability to “Fulfil our role for the communities we serve”. The strategy was in alignment with the local integrated care partnership’s operating plan. These include: Children and Families - Outpatient management of demand, Mental Health - Acute Beds Model, Urgent Care - Sustaining Urgent Care Capacity, Community Health and Care - Admission Avoidance and Planned Care - Outpatient management of demand.

The trust measured progress against delivery of the strategy and the board had oversight of this progression. The director of strategy and performance reported regularly to the board about the trust’s progress against the strategy in their quarterly updates. The trust had a Working Together Strategy Implementation Plan which outlined the plan from implementation by quarter. The plan reflected that at the end of Year 2 Quarter 1 (June 2019) that the trust was progressing against the plan, although there was not evidence they had met all their quarter 1 objectives.

In November 2019 the director of strategy and performance presented a paper to the board entitled Operational Planning- 2019 mid-year review and 2020/21 forward planning. This was in accord with the board request, upon approval of the operating plan, that it be reviewed at mid-year point. This paper included an update on progress with implementation of the 19/20 Operating Plan to deliver the strategic aims outlined in Working Together which reflected that the trust was in line to deliver some but not all of its targets.

The paper reported that there had been progress in a number of key areas of the strategy including for instance, the financial position, CIP delivery, a significant reduction in agency staff costs, improved vacancy and turn-over rates and largely on plan for planned care. There had been a number of positive improvements and deliverables associated with quality of care and treatment provided and during the first six months of the financial year a number of business cases had been progressed or implemented to support delivery of the operating plan.

Paragraph 1:

However, the trust had had to use a financial contingency to mitigate operational risks, there had been some slippage against the capital plan: it was slightly down against plan for unscheduled care activity; further work was required with regard to cancer standards, diagnostic standards, wait times and urgent care performance; and the trust continued to have operational challenges requiring the delivery of improvement plans in the second half of the year.
However, the trust had had to use a financial contingency to mitigate operational risks, there had been some slippage against the capital plan: it was slightly down against plan for unscheduled care activity (apart from type 1 activity which was above plan); further work was required with regard to cancer standards, diagnostic standards, wait times and urgent care performance; and the trust continued to have operational challenges requiring the delivery of improvement plans in the second half of the year.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work but did not always provide opportunities for career development. The trust had an open culture where patients, their families and staff could raise concerns without fear.**

Most staff we spoke to felt respected, supported and valued. Staff of all levels across the trust reported that the trust’s culture had improved in recent years.

Staff felt able to raise concerns. The trust had focused on encouraging people to speak up and providing safe spaces for staff to communicate. The trust had a Freedom to Speak Up Guardian (the guardian) whose role was supported by the board. The guardian had set monthly meetings with the executive Freedom to Speak Up Lead and the chief executive. The guardian was able to contact them, as well as the chair medical director and chief nurse, on an as needed basis.

The guardian supported a network of 20 Freedom to speak Up Advocates (advocates). The advocates all received Freedom to Speak Up foundation training and had monthly meetings.

The trust did not have a Freedom to speak up Policy, however, it had a Whistleblowing policy which included information about the Freedom to Speak Up Guardian. The guardian and advocates roles were publicised across the trust on the intranet and on posters throughout the trust.

The guardian and advocates liaised with groups across the trust. During our core service inspection, we saw that the guardian visited areas of the trust to engage directly with staff. The BAME, LGBT+ and disabilities networks all had a member who was an advocate and the guardian visited union meetings.

The guardian was able to provide examples of how their work had initiated change within the trust. For instance, they were able to describe how a concern raised through the guardian had sparked a clinical audit which verified there was a risk in an area where there was no generally accepted guidance. After the audit a multidisciplinary group joined to review practice and recommend improved ways of working.

There were other supportive organisations within the trust. The trust had several long standing
unions which staff members were able to join. The unions supported their members and professional groups across a range of employment areas.

Additionally, the trust had implemented networks including the BAME, LGBT+ and disabilities network to provide supportive groups to a diversity of staff. Each network had an executive level sponsor to ensure clear communications with and support from the board. These networks provided staff the opportunity to meet together as well as to engage with the greater trust. For instance, through black history month and Pride Parade and engagement at trust events.

Likewise, the trust valued engagement with patients and encouraged patients to raise concerns. The trust had recently moved the Patient Liaison Service to the front of the hospital to encourage patients to raise concerns early.

However, there were still areas where staff felt they were not engaged with, treated equally or where morale was low.

For instance, in the pharmacy team, the staffing numbers were low and staff reported they did not always have funding for specialist training. The lack of suitable training funds for specialist clinical development had impacted on staff morale and progression.

Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. We saw that in the past 12 months, members of staff including band 2 through band 8 and a consultant had been suspended or moved wards after disciplinary reviews.

We were given examples of the medical director addressing concerns around a consultant’s bullying behaviour and other senior members of staff addressing pockets of concerns around allegations of racism and equality.

The culture was not always centred on the needs and experience of people who use services.

At the board level we observed a focus on the patient experience and the needs of people who used the service. The chief nurse was leading a project on compassionate care in support of the trust’s strategic aim to support safe, high quality and patient focussed care. This program was complimented by the culture change program. Both were supported by the board.

During previous inspections we had found a culture of poor care in some departments which was not focused on the needs of people who used the services, in some of the areas visited. During this inspection we found a caring compassionate atmosphere throughout, despite some areas being busy and staff being stretched. In most areas care and improvements from board to ward considered the needs and experience of people who used the service this was reflected in board papers, business cases, the integrated performance report and observations at board meetings and of patient care.
Despite the above improvements, we still found there were areas where culture was not centred on the needs and experience of all people who used the service. For instance, in the emergency department some non-patient centred care had been normalised. Navigating the ED triage process could be confusing, difficult and a risk for an unwell or vulnerable patient. There appeared to be a normalisation of some substandard practices such as lack of oversight of waiting patients, lack of privacy and dignity and care provision in hallways.

Additionally, the hospital was not well signposted and we observed patients regularly becoming lost and confused.

The culture encouraged openness and honesty within the organisation, including with people who use services. Staff thorough the organisation described how the culture had become more open and the senior leaders modelled open and honest communications. The organisation had had a focus on incident reporting and seen an increase in reports of low and no harm incidents which reflected a maturing culture and attitude toward incident reporting.

However, we saw both at core service level and at the senior level that the spirit of the duty of candour was not always followed. For instance, we saw examples of serious incidents having occurred where the trust tried to call the patient or family member one time and when there was no response or returned call, no further attempts were made. In these cases, a letter was sent but there was no further engagement or contact to the patient or family.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution and learning and action taken as a result. Staff felt able to raise concerns. The trust had focused on encouraging people to speak up and providing safe spaces for staff to communicate.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Staff we spoke to on the core service inspections generally described appraisals as thorough and meaningful and the trust was embarking on an audit through the culture change program to understand the quality of appraisal conversations.

However, not all members of staff had the opportunity to benefit from appraisals. Appraisal rates did not meet the trust target of 85%. There were varying levels of compliance across the core services we reviewed. No core service met the target for all staff groups and appraisal rates for individual staff groups ranged from 66.7% to 97%.

The trust put an emphasis on the safety and wellbeing of staff. There were wellbeing programs throughout the trust offering a variety of programs and support systems.
There were also support programs for specific staff groups. For instance, the trust had a large contingent of overseas nurse recruits who come to work at the trust from a variety of overseas locations including India, Philippines and the Caribbean. The trust arranged for the nurses to arrive as a cohort, assisted with settling in the area and provided on-site accommodation. On the nurses first day of induction to the trust, the HR department carried out further checks on each nurse’s documentation. The human resource department created employee personnel files and set each nurse up on the electronic human resources system.

Staff Diversity

Equality and diversity were promoted within and beyond the organisation. Many staff we spoke to told us they felt they were treated equitably. However, some staff members, including those with protected characteristics under the Equality Act, did not feel they were treated equitably.

As of 31 March 2019, Portsmouth Hospitals NHS Trust employed 7,510 people, of which 16% were BAME staff.

(Source: WRES data submission, trust website)

The trust provided the following breakdowns of clinical and non-clinical staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing midwifery staff (%)</th>
<th>Qualified allied health professionals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A White - British</td>
<td>7.4%</td>
<td>20.1%</td>
<td>5.4%</td>
</tr>
<tr>
<td>B White - Irish</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.1%</td>
</tr>
<tr>
<td>C White - Any other White background</td>
<td>1.2%</td>
<td>3.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>E Mixed - White &amp; Black African</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>F Mixed - White &amp; Asian</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>G Mixed - Any other mixed background</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>H Asian or Asian British - Indian</td>
<td>1.3%</td>
<td>2.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>J Asian or Asian British - Pakistani</td>
<td>0.5%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>K Asian or Asian British - Bangladeshi</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>L Asian or Asian British - Any other Asian background</td>
<td>0.7%</td>
<td>2.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>M Black or Black British - Caribbean</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.1%</td>
</tr>
<tr>
<td>N Black or Black British - African</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
The trust’s 2018 scores for the following theme was significantly higher (better) when compared to the 2017 survey:

- Safe environment - violence
The trust’s 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Health and wellbeing
- Immediate managers
- Quality of appraisals
- Quality of care
- Staff engagement

(Source: NHS Staff Survey 2018)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BAME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BAME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.
As of 31 March 2018, two of the ESR staffing indicators shown above (indicators 1a to 3) showed a statistically significant difference in score between white and BAME staff:

1a. In 2018, BAME candidates were significantly less likely than white candidates to hold senior (band 8+) clinical roles (1.1% of BAME staff compared to 4.4% of white staff). This figure was not significantly different to the previous year, 2017.

2. In 2018, BAME candidates were significantly less likely than white candidates to get jobs for which they had been shortlisted (10.3% of BAME staff compared to 15.0% of white staff). This figure was not significantly different to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicators 5 to 8), the following indicators showed a statistically significant difference in score between white and BAME staff:

<table>
<thead>
<tr>
<th>Indicators from the NHS staff survey (‡)</th>
<th>Proportion of respondents answering “Yes”</th>
<th>Are there statistically significant differences between BME and white staff?</th>
<th>This trust and its peer group?</th>
<th>Last year and this year? (BME staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust 31.1%</td>
<td>White staff 28.5%</td>
<td>All staff 26.2%</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>Peer group</td>
<td>Trust 29.9%</td>
<td>White staff 27.9%</td>
<td>All staff 28.7%</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>Trust 25.9%</td>
<td>White staff 26.1%</td>
<td>All staff 27.0%</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>Peer group</td>
<td>Trust 30.1%</td>
<td>White staff 26.0%</td>
<td>All staff 27.0%</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>7. Staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust 74.5%</td>
<td>White staff 89.4%</td>
<td>All staff 87.6%</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>Peer group</td>
<td>Trust 69.6%</td>
<td>White staff 86.3%</td>
<td>All staff 83.3%</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>8. Staff experiencing discrimination at work from a manager / team leader or other colleague?</td>
<td>Trust 14.5%</td>
<td>White staff 6.4%</td>
<td>All staff 7.4%</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>Peer group</td>
<td>Trust 15.8%</td>
<td>White staff 6.7%</td>
<td>All staff 8.5%</td>
<td>BME and white staff?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WRES Indicators from ESR (HR data) (⁄)</th>
<th>BME Staff</th>
<th>White Staff</th>
<th>Are there statistically significant difference between BME and White staff?</th>
<th>Last year and this year? (BME staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8+</td>
<td>1.1%</td>
<td>4.4%</td>
<td></td>
<td>0.1%</td>
</tr>
<tr>
<td>1b. Proportion of non-clinical staff in senior roles, band 8+</td>
<td>2.0%</td>
<td>10.4%</td>
<td></td>
<td>-4.3%</td>
</tr>
<tr>
<td>2. Proportions of shortlisted staff being appointed to positions</td>
<td>10.3%</td>
<td>15.0%</td>
<td></td>
<td>-2.2%</td>
</tr>
<tr>
<td>3. Proportion of staff entering formal disciplinary processes</td>
<td>0.5%</td>
<td>0.4%</td>
<td></td>
<td>0.2%</td>
</tr>
<tr>
<td>4. Proportion of staff accessing non-mandatory training and CPD</td>
<td>91.5%</td>
<td>86.3%</td>
<td></td>
<td>Not assessed</td>
</tr>
</tbody>
</table>

Key:
- Statistically significant or negative finding
- Not statistically significant
- Positive finding
- Statistical analysis not undertaken as less than 30 BME staff responded
- Statistically significant improvement
- No statistically significant change
- Statistically significant deterioration
7. 74.5% of BAME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 89.4% of White staff. This figure was not significantly different to the previous year, 2017.

8. 14.5% of BAME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey) which was significantly higher when compared to 6.4% of white staff. This figure was not significantly different to the previous year, 2017.

There were no BAME Voting Board Members at the trust, which was similar to the expected number, based on the overall percentage of BAME staff.

(Source: NHS Staff Survey 2018; NHS England)

The senior leadership team recognised that BAME staff did not have an equivalent working experience to non-BAME staff and were working to address this. The trust had an Equality, Diversity and Inclusion (EDI) strategy which was incorporated in the Workforce and Organisational Development Strategy 2019-2023. There was a requirement for an annual EDI report to trust Board and a quarterly report to the Workforce subcommittee.

The trust had an equality and diversity improvement plan which reflected that the two overarching workforce equality objectives for the trust were: staff from a minority background or with a protected characteristic report an improved experience at work and managers support their staff to work in culturally competent ways within a work environment free from discrimination.

Likewise, starting in August 2019, all NHS organisations were required to publish a report on the work experience of staff with a disability for the first time under Workplace Disability Equality Standard (WDES). Data collected by the trust for the WDES reflected that disabled staff had a poorer work experience than non-disabled staff.

The trust had created a WDES action plan that addressed a variety of issues for instance, staff reporting their disabilities, opportunities to progress, review of the capability procedure, education, violence, reporting of violence against staff and implementing a disability staff network.

Staff equality was a focus of the trust’s senior leadership team. Staff networks were supported by the trust, the board was focussed on the impact of actions on minority groups and they share information and actions with staff. For instance, the theme of the last leadership conference was Equality. The BAME, Disability, and LGBT+ each were represented, the latest WRES report was available at the event and there were several speakers who spoke about equality including the trust’s chief executive. The summit was well attended by managers and members the trust board.
The trust had an equality, diversity and inclusion improvement plan to address the inequalities for staff within the trust. The plan specifically identified inequalities relating to: gender, race, disability and sexual orientation.

The trust’s equality diversity and inclusion annual report reflected that steps had been taken to start to address inequalities for BAME staff members:

- The BAME staff network was relaunched in January 2018 which now had more than 200 Members.
- It appointed 16 BAME Champions to help shape and influence the EDI agenda/priorities as well as supporting staff to raise concerns.
- The internal Beyond Boundaries positive action Leadership Development programme for BAME staff, which was launched in January 2019, had 24 BAME delegates.
- EDI and Unconscious Bias training was now included in the trust’s Passport to Manage induction programme and would be rolled out to existing managers within the trust.

During the core service inspection, we saw the impact of some of this work. For instance, following a successful recruitment campaign, the trust had recruited large numbers of overseas nurses over the past five years. During our visit, we heard about staff warmly welcoming overseas nurses and helping them settle into the trust and into the local area.

The trust had separately addressed issues relating to equality and diversity when specific concerns were raised about a group or area of staff members. This was addressed through an awareness-support-signposting methodology. In one case the trust directed unconscious bias training, focusing on the impact of unconscious bias to a specific group where data reflected weaknesses regarding equality and diversity.

However, fundamental challenges to BAME staff continue. BAME staff were less likely to be appointed from shortlisting; more likely to enter the formal disciplinary processes and more likely to experience bullying, harassment or abuse from patients, relatives and staff than white staff. These issues have been verified in the WRES data and by members of the BAME network as well as senior leaders in the trust.

With regard to LGTB+, the trust had seen improved engagement and support including the implementation of a new LGTB+ network in June 2018 which contributed to the production of a Rainbow Badge toolkit and informed the trust’s Trans support policy for staff.

The trust’s EDI report reflected that although the trust had started measuring and considering information about disabled staff, it had not yet taken actions which have impacted the inequity felt by staff members living with disabilities.
Likewise, the trust had identified challenges that created or supported the gender pay gap within the trust, but they had not yet taken actions that have impacted this inequity.

There were cooperative, supportive and appreciative relationships among staff. Staff and teams generally work collaboratively and share responsibility. However, we saw some lack of recognition about how each patient’s treatment and stay impacts both patient flow and the impact of this throughout the trust.

Teams were supported to work in a multidisciplinary way. The hospital’s simulation centre provided a dedicated training environment with scenario-based learning from a variety of clinical settings which encouraged multidisciplinary training. For instance, staff attended multidisciplinary simulation training to help them learn to respond to different emergency and non-emergency clinical situations. Some staff we spoke to described a multidisciplinary emergency airways simulation training they attended.

The core service inspections reflected how teams work together to provide holistic treatment to patients. Generally, staff members provided complete handovers and shared information. They were willing to work together to identify and support patient needs. Staff spoke of positive relationships between different staff groups. Patient records reviewed during the core service inspection demonstrated multidisciplinary input into patients’ care from a variety of professional groups.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service also worked well with neighbouring trusts to deliver speciality care.

The trust liaised with other regional mental health care providers at the multidisciplinary mental health and capacity board which included the trust’s chair and medical director, divisional leads psychologists, paediatricians, emergency medicine doctors, educators and representatives from regional mental health care trusts. The group discussed a variety of issues related to mental health care safety and provision. The trust medical director added risks identified at the mental health and capacity board to the board risk register for escalation and oversight.

However, we saw that the IT infrastructure did not always support this multidisciplinary working. For instance, flags put on records in one department about a patient’s status might not be reflected in other department’s systems. As a result, if a patient was having treatment in different areas, those caring for them may have different information.

**Friends and family test**

The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.
The trust scored between 95.9% and 98.6% between August 2017 and July 2019. The data appeared to be stable with only random variation over the whole period.

(Source: Friends and Family Test)

**Sickness absence rates**

The trust’s sickness absence levels from May 2018 to April 2019 were consistently lower than the England average.

(Source: NHS Digital)

**General Medical Council – National Training Scheme Survey**

In the 2018 General Medical Council Survey the trust performed the same as expected for all indicators.

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

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services which were regularly reviewed and improved.

The trust had reviewed its governance processes internally and with a recognised external audit, consulting and advisory firm. As a result of these reviews the trust had changed its governance structure. Staff and leaders reported that the new structure provided clear channels of communication and oversight.

The board had a committee system which ensured the appropriate issues, information and concerns were escalated to the board. There were five committees that report to the board: quality and performance, nomination and remuneration, finance and infrastructure, workforce and organisational development and audit. Eight subcommittees fed into the quality and performance committee including emergency preparedness, patient safety, patient experience, clinical effectiveness, safeguarding, health and safety children and young people and maternity. Likewise, four sub-committees fed into the finance and infrastructure committee including business case review, capital priorities, IT and estates.

The committees each had executive and non-executive members and a non-executive chair. We observed that committee meetings were well attended by members, divisional directors, other members of staff who were relevant to the discussion and the CCG. There was a clear agenda which the chair followed.

We observed detailed conversations in committee meetings where both executive and non-executive members engaged in discussion and there were high levels of challenge. At one meeting we noted that there were a large number of people at the entire meeting. On discussing this with senior leadership they advised that they were reviewing attendance to ensure the right people were in the meetings so to ensure involvement of the group members.

At the quality and performance committee we saw the committee shared meaningful papers which provided relevant information. They used an integrated performance report to share topical and up to date information and received updates from sub-committees. They considered issues in the heat map and discussed regular and thematic reviews and the risk register. The committee provided challenge with regard to the topics on the agenda but also related to the underlying information, for instance discussing the data and information they relied on and whether it was
effective in providing information and assurance or if there might be other information that brought more insight. The members were open to requesting and reviewing different kinds of information to provide necessary details and assurance.

The trust had a well-developed governance system for medicines. Pharmacy leaders were present or represented at all relevant meetings and committees where matters addressing medicines use in the trust were discussed.

The chief pharmacist reported that they and their team received constructive challenge from the non-executive directors in committee and other governance meetings. Where systems had previously been weaker, for example the trust’s review of Patient Group Directives, the team had implemented new, more robust, systems.

The medicines safety committee ensured all pharmacy actions agreed at committee were completed in the established timescale. This committee ran a tracker where each action was red, amber, green (RAG) rated and allocated to a specific person to hold responsibility for completing the action.

**Board Assurance Framework**

Trusts are required to provide effective and comprehensive processes to identify, understand, monitor and address current and future risks. The board assurance framework provided the structure for this oversight. The trust’s board assurance framework reflected the risks to the initiatives in the strategic plan and the board used it as a tool to maintain oversight of those risks.

The trust provided their Board Assurance Framework, which detailed the five strategic objectives set out in the trust strategy (Working together):

1. We will fulfil our role for the communities we serve.
2. We will support safe, high quality patient-focused care.
3. We will take responsibility for the delivery of care now and in the future.
4. We will invest in the capability of our people to deliver on our vision.
5. We will build the foundations on which our team can best deliver care.

The 23 identified risks to delivery of these objectives were set out in the Board Assurance Framework, along with action plans for their mitigation.

*(Source: Trust Board Assurance Framework – May 2019)*

Prior to the inspection, the trust provided a document which included their six highest profile risks. Each of these had a current risk score of 15 or higher. The below risks all had a risk status
of ‘red’. Red risks are those which would have a major or catastrophic impact on the trust.

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk summary</th>
<th>Risk score (current)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF2</td>
<td>The trust’s information technology (ICT) systems do not provide adequate support for delivery of trust objectives</td>
<td>20</td>
<td>April 2019</td>
</tr>
<tr>
<td>BAF14</td>
<td>The trust faces challenges in recruiting and retaining staff in a number of key areas</td>
<td>20</td>
<td>April 2019</td>
</tr>
<tr>
<td>BAF19</td>
<td>There are concerns about the integrity of data in some non-18 week waiting lists</td>
<td>16</td>
<td>April 2019</td>
</tr>
<tr>
<td>BAF1</td>
<td>Urgent care, quality, performance and patient flow</td>
<td>16</td>
<td>April 2019</td>
</tr>
<tr>
<td>BAF8</td>
<td>Demand for mental health services in the trust exceeds mental health resource available (capacity and quality)</td>
<td>16</td>
<td>April 2019</td>
</tr>
<tr>
<td>BAF26</td>
<td>Trust’s year-end financial forecast 2019/20</td>
<td>15</td>
<td>April 2019</td>
</tr>
</tbody>
</table>

(Source: Board assurance framework - May 2019)

The board assurance framework was a living document. At the time of the well led inspection in November 2019, the top five risks on the trusts board assurance framework were:

- Urgent Care, Quality, Performance and Patient flow
- Demand for mental health services in the Trust exceeds mental health resource available (capacity and quality)
- Reduced capacity arising from changes to application of pension taxation rules
- Pressures on system partners may compromise their ability to prioritise work streams and actions which support delivery of Trust objectives
- Trust’s year-end financial forecast 19/20

The board assurance framework outlined 23 risks linking them to one or more of the above strategic objectives. It provided an overview and management of each risk. The board reviewed the board assurance framework in its entirety on a quarterly basis. All risk scores were considered and an update against each outstanding action was provided including a summary of actions since the last review.

The trust’s focus on some areas had seen improvements, for instance with regard to IT and staffing where risks had been addressed or mitigated.

However, other risks’ ratings had increased. This was particularly highlighted in areas around the emergency and mental health provision. We observed that the board had sight of these issues and had implemented changes, however the high risk to patients continued or increased.
The board assurance framework was a standing agenda item at all board meetings to give the board the opportunity to consider how any discussions at board could impact existing risks or whether new risks needed to be added.

All levels of governance and management functioned effectively and interacted with each other. As a result of internal and external reviews the trust had changed its operational structure in 2018 to include four divisions: medicine and urgent care, surgery and outpatients, networked services and clinical delivery. There were ten care groups or specialties grouped within the four divisions. This provided an oversight structure where the board had oversight of the divisions which had oversight of care groups and information fed in both directions through the structure.

Each division was led by a triumvirate including a medical director, nurse director and ops director. They worked closely together to ensure governance within the division and fed information directly to the executives and through the committees to the board.

The divisions had monthly governance meetings and kept their own risk registers so that the triumvirate had oversight of the care groups. The divisions had recently embedded human resources and finance business partners to provide support.

The divisional triumvirate leaders had monthly performance and accountability meetings with the executive directors including the chief executive. The divisions provided updates with regard to serious incidents, risk register, patient feedback, success, finance, human resources and performance data at these meetings. Each month the division presented a ‘spotlight review’ where an issue from the division was highlighted and discussed.

Board members were clear about their roles but not all staff below the board level were clear about their roles and accountabilities.

The trust had performed a review at board level which had clarified job roles. Following this work, executives and non-executives understood their own job roles as well as responsibilities and accountabilities as individuals and as a board. Both executive and non-executive directors had clearly defined roles and responsibilities but also understood their joint accountability and offered challenge and support, within and outside of their expertise, as a unitary board.

However, the clarity around job roles at the most senior level did not extend to lower band roles. There was not a clear accountability framework with transparent role expectations that applied to the new context of the trust. Roles and responsibilities were not always clear from band two through band 8 and while this impacted role descriptions of all bands, it was particularly applicable to roles at the middle management level.
Arrangements with partners and third-party providers were governed and managed to encourage appropriate interaction and promote coordinated, person-centred care. However, the provider and partners were not always able to provide that person-centred care.

The trust had partnerships and relationships with three local CCGs, the city and county council, NHSI/E, system provider partners, the local university and Healthwatch. Senior leaders engaged with partners unilaterally and as part of various platforms to find ways to work together.

The trust had contracts with the CCGs and met with them in various fora. It worked directly with other system providers in system meetings, one-to-one and joining board meetings for instance. The trust was working with system partners to support each other, share and benefit from expertise, consider system working and develop efficiencies across the region.

The trust had arrangements to make sure that hospital managers discharged their specific powers and duties according to the provisions of the Mental Health Act, but the arrangements did not always meet patients’ needs. The trust had taken some steps to meet patients’ needs but many of these arrangements had recently been introduced and were not yet imbedded.

The trust had agreements with two regional mental health trusts to provide support for patients with mental health needs, including children and young people and those patients detained under section 136. The trust did not have a 136 suite; two other trusts operated 136 suites in the region. Patients brought to the Queen Alexandra Hospital site under section 136 were held in a side room of an observation ward attached to the main Emergency Department (ED) or within the ED itself, until a space in a regional designated Section 136 Suite became available or until the patient’s section was lifted.

In September 2019 the trust introduced a 24/7 Mental Health Liaison service and an improved Children and Adolescent Mental Health Services (CAMHS) service to support the ED was reinstated by Commissioners. Additionally, in November 2019 they jointly, with one of the local providers, appointed a mental health matron to improve the quality and consistency of services provided to mental health patients. It was too early to see the impact of these initiatives.

Patients who required medical management could be admitted to a general hospital ward with internal staff and support from the regional mental health trusts. Staff were supported by the two regional mental health trusts and the Portsmouth and Hampshire child and adolescent mental health services, out of hour GPs and consultants and NHS 111 mental health nurses.

The trust recognised the challenges to quality and availability of mental health care in the trust. This issue was on the board assurance framework with ownership by the trust’s medical director. There were nine actions for follow up on the board assurance framework, three were complete, four were on track and one, the restraint task and finish group was overdue. The overdue action was regularly updated and the completion expected two months after the original date.
Management of risk, issues and performance

The trust had a risk culture which focused on identification and management of risks using assurance systems. Most risks were identified and escalated relevant risks and issues and identified actions to reduce their impact, however, some risks were not identified.

Staff at all levels recognised their responsibility for risk and incident reporting. The trust had worked with staff to improve incident reporting and as a result the number of incidents, in particular no and low harm incidents had risen and, staff and management, actively managed risks across the trust.

The trust had a revised incident review process which included a weekly incident review panel of all incidents with potential significant learning as well as those causing harm which was chaired by the medical director or their deputy. A summary of all cases was presented to the leadership team at a meeting weekly and cascaded through divisional structures. The integrated performance report included a section on patient safety events, serious incidents and never events, this included monthly updates on pressure ulcers and falls.

The care groups had governance meetings including actions and learning from local events. A serious incident review group met monthly with representation from each care group to share learning from serious incidents. The safety team provided feedback to learning and development to inform training.

The trust had oversight of risks related to medicines. The pharmacy and medicines risks were recorded in the trust risk register and reviewed monthly. The pharmacy department had created a new post, governance risk education assurance training pharmacist, to lead on risks related to medicines. This role was to sit within the medicines optimisation team in the trust. Information about medication safety was included in the monthly integrated performance report.

However, we did see that some risks did not appear to be identified as risks where practices had become ‘business as usual’. For instance, at the time of our core service inspection, in the emergency department waiting room patients entered the waiting room and waited for a navigator nurse without any oversight or direction. This could leave vulnerable or ill patients waiting longer than more fit patients. Likewise, patients in the waiting room would wait for hours to be seen without any oversight or observations from trained staff. Although these risks were visible risks on entering the department, they were not identified by the trust. The risks were addressed proactively when they were raised by CQC, but following that, gaps in cover were not identified by the trust as a risk.

The trust had a systematic programme of clinical and internal audit to monitor quality, operational and financial processes and systems to identify where action should be taken. The trust had an
audit program that included audits at divisional, and provider level. The trust submitted information for national audits.

National clinical audit results were reviewed by specialty leads and shared at the recently relaunched clinical effectiveness committee. It was then fed into and considered by the quality and performance committee which reported to the board. National audits which highlighted negative results required a risk review and action plan. For instance, the Sentinel Stroke National Audit Programme, National Lung Cancer Audit (both highlighted in the 2018/19 quality account) and National Maternity and Perinatal Audit all required action plans in the past year.

A summary report of national audits was included as a section of the quarterly clinical effectiveness report to the quality and performance committee. The chairs of all the board’s committees met twice a year to ensure plans and actions between the committees were coordinated.

The trust was able to demonstrate how they used audit information to inform care decisions, for instance, changes to protocols, intra-departmental agreements about patient care, implementing education, sharing of information, improving documentation and use of new tools to monitor and check.

The trust shared outcomes with the public in its 2018/19 quality account. It highlighted details of sub-optimal audits including Sentinel Stroke National Audit Programme and National Lung Cancer Audits as well as those that demonstrated the trust’s performance at or above national average level including, National Hip Fracture Database, National Neonatal Audit Programme, Chronic Obstructive Pulmonary Disease Audit, National Audit of Care at the End of Life and National Ophthalmology Database Audit.

The trust relied on external auditors to audit finance and governance functions. An external auditor assessed the trust’s finances yearly and the trust had recently had a review and audit of the governance functions resulting in changes to the structure of the trust’s governance.

The trust had arrangements for identifying, recording and managing risks, issues and had identified actions to reduce the impact of them.

The trust used a risk register system to manage risks of all levels. Risks were recorded on registers which were used to ensure oversight and management of the risks. Core service level risks were held on a divisional risk register. Risks that were high level or affected multiple core services were added to the trust risk register. The quality and performance committee reviewed the risk register prior to its presentation to the trust Board. The board had final oversight of the trust risk register.
For instance, pharmacy leaders identified the risk of disruption due to the age of the aseptic manufacturing unit. This was placed on the trust risk register; the department was pursuing a business case and the capacity in the local area and the ability to source pre-made products was part of the plan to manage possible disruption.

The trusts risk register had 11 risks currently rated as high. These included:

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory impact of breaching 4 hour access standard</td>
<td>20 (4x5)</td>
</tr>
<tr>
<td>Compromised care of patients with primary mental illness due to lack of specialist knowledge, provision and training.</td>
<td>16 (4x4)</td>
</tr>
<tr>
<td>Disruption to clinical services arising from breakdown in sterilisation and high level disinfection equipment</td>
<td>16 (4x4)</td>
</tr>
<tr>
<td>Patient harm arising from lack of timely discharge</td>
<td>16 (4x4)</td>
</tr>
<tr>
<td>Patient harm arising from stretched pharmacy services in times of significant pressure</td>
<td>16 (4x4)</td>
</tr>
<tr>
<td>Patient Harm due to inability to treat with bespoke aseptic products due to failure of pharmacy manufacturing unit</td>
<td>16 (4x4)</td>
</tr>
<tr>
<td>Risk of enforcement action/financial penalty from the ICO for failing to meet SAR deadlines</td>
<td>16 (4x4)</td>
</tr>
<tr>
<td>Increased demand for NTProBNP Clinic could result in breaching pathway.</td>
<td>15 (3x5)</td>
</tr>
<tr>
<td>Potential severe patient self-harm if potential ligature points are not removed trust wide.</td>
<td>15 (3x5)</td>
</tr>
<tr>
<td>Damage to trust reputation arising from non-compliance with internal policy and Nice Guidance relating to restraint.</td>
<td>15 (3x5)</td>
</tr>
<tr>
<td>Risk of reputational damage/harm to regulatory relationships arising from failure to deliver annual financial outturn forecast.</td>
<td>15 (5x3)</td>
</tr>
</tbody>
</table>

We saw that each of these risks had board oversight and regular review. Most of these risks were also included on the board assurance framework due to the impact on the trust’s strategic objectives. However, risk levels related to most of the objectives had not changed with only two significantly improving and the highest risk, related to the emergency department, having increased. Notably, the risk and corresponding risk level relating to the trust’s emergency department had not improved despite significant investment in the area by both the trust and system.

Potential risks were taken into account, but were not always addressed, when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The trust worked independently and with system partners to prepare for a wide variety of risks. Emergency preparedness was on the trust’s board assurance framework, so
the board would have oversight of the risk and the possible impact on the trust's meeting its strategic objectives.

All NHS Organisations are required to prepare for and respond to a wide range of incidents or emergencies that could impact on health or patient care. This work was referred to as ‘Emergency Preparedness, Resilience and Response’ (EPRR); in 2019 it laid out 64 required standards.

A clinical commissioning group review of the trust's readiness under the EPRR and found the trust to be compliant with 53 of these standards, partially compliant with ten and non-compliant with one; it was rated overall as partial compliance. The trust’s internal review also concluded that it was partially compliant with the standards. The cause of the partial compliance was primarily that the trust had not ratified plans or had not tested or exercised existing plans. The trust had an action plan to address these issues, but not all planned actions were expected to be completed before September 2020.

The trust had a 2019/20 winter plan to manage and address risks of increased use over the winter months. The plan stated that its aims were to ensure patients and staff had an improved experience by taking steps such as reducing occupancy, delivering plans for treating emergency cancer and elective patients; reducing the number of patients who were medically fit for discharge, reducing ambulance delays, and managing risks relating to flu.

The trust intended to meet its goals, in part, by taking learning from the previous year to deliver on a whole system plan. It focused on addressing several key factors which primarily effected available beds and flow. At the time of this review the trust had had mixed success in managing these key factors. For instance, it had relaunched the frailty unit and was increasing its early morning discharges toward the target of discharging 33% of patients before lunchtime.

However, the winter plan anticipated increasing bed numbers by reducing the number of medically fit for discharge patients to less than 130; but the November 2019 integrated performance report reflected that this number had averaged 204 in the previous month. Further, it showed the total number of medically fit for discharge patients was increasing and was at its highest point in the past year.

When considering developments to services or efficiency changes, quality and sustainability was assessed and monitored. All evidence we reviewed reflected that financial pressures did not compromise care at the trust.

When changes were made requiring funding, a lead needed to submit a business case for review and approval. Business cases would be reviewed by the business case review sub-committee.
which would make recommendations to the finance and infrastructure committee. That committee then made recommendations to the board where the proposal exceeded the committee’s delegated authority. Where relevant, other committees would review business cases.

Where the committee was asked to consider business cases it sought assurance regarding consistency with the trust’s strategy, process, governance and value for money before recommending to the trust board for approval. Each proposal included a quality impact statement. We observed challenge with regard to impact of quality, cost and supporting information regarding business cases at board.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£543.1m</td>
<td>£558.7m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£31.8m)</td>
<td>(£37.9m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£574.8m</td>
<td>£596.7m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£9.7m)</td>
<td>(£29.9m)</td>
</tr>
</tbody>
</table>

The deficit reported in 2018/19 was greater than the previous year. Projections for 2019/20 suggested a reduction in the budget deficit to zero, which was also projected for 2020/21.

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

The trust’s risk of reputational damage arising from the possible failure to deliver annual financial forecast was on the trust’s risk register and board assurance framework. The trust had a past record of delivering financial deficits but appeared to be benefitting from having strengthened its financial governance in recent years.

The trust was delivering against its financial recovery plan at the end of 2019/20 quarter two. It was on track to improve its financial position in 2019/20 with expectations that it would meet its quarter three targets. However, the trust acknowledged that meeting the quarter four commitments
was not inevitable due to several challenges in quarter four including issues around winter pressures and delivering on the cost improvement program.

The trust’s financial risk management was led by the trust’s chief financial officer. Financial oversight and challenge was provided by the finance and infrastructure committee which included three non-executive director members including the chair who reported to the board. Four sub committees reported into the finance and infrastructure committee including the business case reviews, capital priorities, IT and estates subcommittees.

The chair of the finance committee did not have a financial background although the other committee members did. Members explained that this supported all committee members to offer challenge and to work as a unitary committee of the board.

The trust also had a clinical director for finance who had both a clinical and financial experience. This role provided medical insight into financial discussions. The clinical director for finance sat in on the finance committee and the cost improvement plan program board and the weekly financial meeting with the trust chief executive officer to ensure the clinical perspective was represented and heard.

Information management

At board level there was a holistic understanding of performance, which covered and integrated people’s views with information on quality, operations and finances, the service collected reliable data and analysed it and information systems were secure. However, data or notifications from some areas of the organisation were not consistently submitted to external organisations as required, staff could not always find the data they needed and information systems were not integrated.

The board used an integrated performance report (IPR) to gain a holistic understanding and overview of the trust’s performance. It provided an overview of key safety and organisational indicators regarding performance, workforce and organisational development, finance, quality and outcomes. Within each of these areas the board had identified matters which require regular board oversight. For each area the IPR outlined indicators of actual performance, drivers of performance and balancing measures. In this way the board aimed to capture the performance against risks, clarify what was driving performance and maintain oversight of other areas which could be negatively impacted by improvement measures.

For instance, the integrated performance report provided information regarding patients’ pressure ulcers and falls. The actual performance measures included pressure ulcer by category, falls and pressure ulcers by bed days. Drivers included bed occupancy, assessments and patient
repositioning audits and balancing measures included pressure ulcer comparison 2018 to 2019, learning themes and total falls by month. These measures were identified and discussed by the relevant oversight committee, the value of the measures was actively discussed and new measures were identified and implemented when agreed by the committee.

The IPR included quality and safety of clinical issues, finance, regulatory matters, patient experience overview, and an operational performance report. It also included an overview of key performance measures related to urgent care, which was the trust’s highest clinical risks.

The IPR was updated monthly and used as an oversight tool at each board meeting. The board used this tool as a structure for the board’s discussion reviewing each area of the IPR in line with the committee reports, executive reports and other elements of the agenda. In this way each member of the board could review and have the opportunity to discuss or challenge each measure. We observed the board using the data and information to offer challenge as well as challenging how some of the data provided the information necessary for their oversight.

Quality and sustainability both received sufficient coverage in relevant meetings at all levels. Quality and sustainability were each features of Working Together the trust’s current strategy. Throughout committee and board meetings we observed discussions of quality and sustainability with regard to the matters of discussion. Executive and non-executive board members provided challenge with regard to quality and sustainability regularly in meetings. Likewise, board papers and business cases considered both quality and sustainability.

While we observed discussions of sustainability versus quality, we did not see any examples of safety being outweighed by financial considerations. On discussing the matter with board members none were able to provide any examples of this occurring.

The trust had a patient management and discharge system which provided some information staff needed. However, staff did not always have all the information they needed.

All staff had access to an electronic records system that they could all update. The information technology systems were used effectively to manage patient flow through the hospital with a real time display providing up to date information. This included clear and robust service performance measures, which were reported and monitored.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Key performance indicator dashboards and assessments were held for each division. This reviewed quality, workforce, finance and responsiveness.
Monthly audits of patient safety outcomes were displayed for staff and motivated them to improve on any that did not meet the targets. Patient feedback information was also discussed to identify areas of good practice and areas which required improvement.

The pharmacy team monitored and reviewed key performance indicators for the pharmacy service. An example of this was the system for medicines reconciliation on admission. The current rate of medicine reconciliation on admission varied between 75% and 80% in 24 hours. However, Monday to Friday this rises to 90%. Pharmacy leaders were aware of this discrepancy and report it to TLT. However, as a full seven day service was not provided, to mitigate this risk a flag was now added to Bedview to enable pharmacy teams to prioritise their resources.

Controlled drugs were monitored to enable any unusual prescribing to be investigated and quarterly incident reports were submitted.

However, the organisation had many systems which were not integrated and were not always reliable which added to the lack of consistent experience across the system. On the core service inspection, we found that not all staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. For instance, staff in the maternity department, did not always have the information they needed and the trust's data submissions for maternity services was inconsistent and not always accurate.

There were effective arrangements to ensure that the information used to monitor, manage and report on quality and performance, which was accurate, valid, reliable, timely and relevant. Data quality across the trust had improved although the trust had 'not fully met' required standards and there were still concerns around data quality in some areas.

The trust had a data quality policy which noted, “Good quality information underpins the delivery of effective patient care”. It required that all staff take responsibility to ensure that data collected, recorded, analysed and reported was accurate, reliable and consistent. The trust had focused on improving data quality in recent years and data collection was supported by validation and audit programs to ensure quality.

The trust had recently created the role of the chief information officer. The director of governance and risk, chief information officer, and head of information technology worked collaboratively to address data quality and security.

The trust had a Data Protection and Data Quality Committee which included for setting the trust’s strategy for maintaining and improving data quality and providing assurance of data quality within the trust, identifying risks posed by poor data quality. The group was chaired by the director of governance and risk, who was also the SIRO and reported to the Board's Quality & Performance Committee.
The Data Protection and Data Quality Committee oversaw the delivery of the NHS Data Security and Protection (DSP) Toolkit standards to evaluate the trust's data quality. The toolkit evidence was examined by an external auditor, reviewed by the board and authorised for submission by the board in March 2019.

Portsmouth Hospitals NHS Trust Information Governance Assessment Report overall score for 2018/2019 was ‘standards not met’ The trust submitted an improvement plan for the standards where assurances could not be given. NHS Digital had since evaluated the improvement plans and changed the score to ‘standards not fully met (Plan Agreed)’.

Information technology systems were not always used effectively to monitor and improve the quality of care.

The trust currently had a low level of digital maturity and multiple challenges with the current state of its IT systems. These systems were often slow, difficult to use or interoperable and legacy systems were not integrated with each other or newer systems.

The leadership recognised both the current low level of digital maturity and the challenges with the current state of IT legacy systems. In response they had created a comprehensive five year digital strategy to develop both the organisation’s digital maturity and replace or improve digital systems. The plan included internal and external solutions to the trust’s technological challenges.

The trust had taken some significant steps toward a more mature and effective IT system. For instance, it had internally developed systems including ‘Minestrone’ and its award nominated bed and discharge management system, both systems had been embedded and significantly increased real time oversight of patient care. The trust had arrangements to ensure data or notifications were submitted to external bodies, but this did not always ensure they were submitted. Data or notifications from most areas of the organisation were submitted in accordance with requirements. However, data and notifications in maternity were not always reliable and were not consistently submitted to external organisations as required.

There were arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

According to the trusts 2018/19 quality report, the trust reported five serious incidents to the Information Commissioner’s Office (ICO). Action was taken in response to these incidents, for instance the revocation of IT access. Learning had been taken from the incidents and staff were educated about the consequences of information governance breaches. The trust reported that there were no outstanding actions with regard to these matters.

The team advised that there had been no recent security issues of ICO declarations.
There were arrangements to ensure that recruitment IT systems and processes were fit for purpose and met requirements for Information governance and corporate governance.

We reviewed employee records and saw that employee details were held on the trust’s employee records system. The system allowed managers to record and review training and development, annual leave, sick leave, statutory and mandatory training, individual performance reviews, appraisals and professional revalidation. The system had built in prompts to alert managers, human resources or the training and development team when key statutory and mandatory training needed to be completed and when individual performance reviews and appraisals were due.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The views of people who used services, those close to them and their representatives were used to shape the services and were actively engaged and involved.

People’s views and experiences were gathered and acted on to shape and improve the services and culture. The board relied on patient feedback to inform the monthly integrated performance report. The report included trends and themes from complaints, compliments and friends and family test responses.

The board had recognised the need to engage with patients who were vulnerable or did not always speak up. In the 2018/19 quality report the trust reported it had introduced more accessible ways for people to provide feedback about their experience. These included easy-read surveys and questionnaires for people with additional communication needs, text messaging for the Friends and Family Test, and face to face visits to community groups to receive direct feedback.

The trust created forums to ensure patients had a voice in the trust’s development and improvements. In 2015 the trust formed a patient collaborative to provide patient perspective to the trust. This was an active group which the trust actively engage with. The trust’s patient, family and carer collaborative won the Pride of Portsmouth Inclusivity Award in December 2018, for its contribution to ensuring that the voices of a diversity of people were heard and their concerns were acted on.

The trust engaged with patients to inform the strategy, Working Together. They involved patients and public in a variety of ways from short postcards to a patient collaborative meeting and workshop. Individuals included representatives of GP practice PPG, LGBGT support groups and the disabled community. The trust’s document, *Working Together What we’ve heard*, outlined how
information from this engagement was used to hone the strategy with regard to the vision, values and strategic aim.

Likewise, the provider used a patient and staff collaborative to feed into equality objectives. The sessions opened up discussions with all group members and gave patients and staff the opportunities to share their experiences to shape the equality objectives.

The provider engaged patients with regard to the research program which was a thread throughout the trust. For instance, it reached out to the public with its ‘pint of science’ sessions where people met in a pub to hear about research, used social media to communicate with the public about current and future research and ran an annual hackathon half day event.

The senior leadership team engaged with the public through a variety of mediums. They had held two open sessions with patients where they requested feedback in the hospital reception areas, held public meetings and had a social media presence. The social media program had included a live chat with the chief executive and strategy director which received over 5000 views and 116 comments.

The annual report reported that by improving access to feedback opportunities, the trust had increased the number of patients who provided feedback about services from about 3500 to over 6000 per month.

The trust actively engaged with staff so that their views were reflected in shaping the culture, including those with protected equality characteristics.

The trust used an array of means to engage with staff about topics that affected them. Staff on the core service inspection overwhelmingly told us that they felt engaged by their immediate managers and more generally at the trust. However, evidence reflected that there were some pockets of staff who did not feel they were involved in changes to the service structure which affected them.

There were opportunities for engagement at team, divisional and trust level. Staff were directly engaged at team meetings and through regular catch ups. At the trust level, the trust had the annual survey which provided the opportunity for anonymous feedback. There were also events with senior leaders, meetings, drop in sessions, and the opportunity for clinicians to feed back at the clinical reference group.

The board focused on ensuring staff fed into the trust strategy. They held 92 interviews and meetings, joined nine team meetings, held six drop in sessions with 90 attendees, conducted a survey and held four clinical reference group meetings. The trust’s document, *Working Together What we’ve heard*, outlined how information from this engagement was used to hone the strategy with regard to the vision, values and strategic aim.
The trust held Listening into Action sessions to discuss actions in response to Workplace Discrimination Equality Standard (WDES) data, the result was the implementation of a disability network and the disability passport which reflects individuals needs and accommodations.

The trust was using the same framework to consider the action they will take regarding the gender pay gap.

The trust held a wide variety of training and informational events to engage with staff with regard to clinical matters, culture and change. For instance, during our inspection we observed there were trolley dashes for malnutrition and international infection prevention week, a showcase of quality improvement work, a patient research ambassadors meeting, a simulation training event for Mental Capacity Act and Deprivation of Liberties scenarios and two ‘Big Room discussions’ which all staff were invited to where the topics were frailty and orthopaedic revision joint surgery.

The trust held other events throughout the year for instance an annual medication safety drop-in day. At the last medication safety drop in day, a number of stands showcased different medication safety topics such as oxygen prescribing, insulin prescribing, use of syringe drivers and checking medicines for patients going home. More than 270 hospital staff attended the event.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, although the system did not always deliver services to meet those needs.

The vision and strategy highlighted the importance of working with local and regional partners. The trust engaged with partners to support system wide working on a regular basis considering contracts, strategy, operations and regulatory oversight. Partners included three local CCGs, the city and county council, NHSI/E, other regional system provider partners, the local university and Healthwatch. Senior leaders engaged with partners unilaterally and as part of various platforms to find ways to work together.

The trust was an active member of the regional sustainability and transformation partnership which provided a forum to deliver improvements to health and care from a regional perspective. The trust was currently meeting with the STP to consider priorities for the implementation of the NHS Long Term Plan across Hampshire and the Isle of Wight.

Board members worked with other regional providers to manage the provision of care across the patch. The senior leaders met with the CCGs and other regional trusts including attending some regional provider board meetings to identify ways to improve care and efficiencies and to address specific challenges, for instance relating to urgent and emergency care and mental health provisions.
The trust spoke to partners throughout the process of developing their strategy. They recognised that they were already working well with partners in some areas. The trust stated that they had had 16 meetings with external partners to discuss the strategy.

Divisional leaders and directors also engaged with partners to benefit the region and the trust. For instance, the research team engaged with councils, CCGs, charities, the local university and local industry to drive the hospitals research program. Pharmacy professionals were involved in transfer of care projects with local CCG colleagues to improve medicines outcomes for patients on discharge.

There was transparency and openness with all stakeholders about performance. The trust was actively engaged with its stakeholders including contracting bodies, NHSI/E and regulators. The trust submitted notifications and information in compliance with regulation.

The trust published its monthly integrated performance report on the trust website which provided a monthly update on regulatory compliance, quality and safety, operational performance, workforce and finance.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff strove for continuous learning, improvement and innovation including participating in research projects and recognised accreditation schemes.

The trust had a research strategy which was part of a wider corporate strategy and included collaboration with the local university under a strategic partnership agreement to drive the research program. The strategy included a five year research and innovation plan 2015/2020 which the trust was delivering on.

The trust had a dedicated research team which was responsible for management, administration and the governance framework that research sat under. The research department had grown exponentially in the past 10 years from three staff members to 142.

The director of research and innovation led the team with the support of three senior members.

During 2018/2019, the trust participated in a total of 354 clinical research studies; 86% of these studies met the requirements for, and were adopted into, the National Institute of Health Research Portfolio. All studies were reviewed and approved by the research ethics committee.
More than 25 clinical departments within the hospital had participated in research at the trust during 2018/2019. The research included a broad range of specialities and clinical support departments.

There were 11,653 patients receiving NHS services provided or sub-contracted by the trust in 2018/2019 who were recruited to participate in research at the hospital. This was a huge achievement with only one other trust in the country recruiting more patients to research studies.

The trust worked with local regional and national organisations to support the research programs. It was overseen by the Wessex clinical research network. The network monitored performance and benchmarked the research nationally.

The trust had a research governance group. This group reviewed the research and any incidents that were submitted with regard to research. It provided a bi-monthly report to the quality and performance committee. Any incidents were reported to a generic mailbox, reviewed internally by the trial managing group, submitted as an incident, and escalated through the governance structure. Any study that was contracted to the trust by a private entity had its own external protocols which would also be followed by the contractor.

All of the trust’s patient research had been approved by a research ethics committee. The trust was involved in low risk, observational studies all of which had standard operating procedures.

The trust’s research provided a wide range of insights and benefits that directly benefited the trust’s patients. For instance, NICE had adopted research outcomes from the program relating to the treatment of asthma, there was an award winning ‘toolbox’ for the delivery of training, and a smoking cessation program which the trust adopted for patients and staff alike.

The board supported innovations and innovative thinking throughout the trust. One area where the trust used innovative methods to address a high risk issue was with the implementation of their overseas recruitment program to increase staffing numbers. The trust utilised the services of four international recruitment agencies who have offices in the countries where they recruited nurses. They worked to a strict contract with the trust. The primary requirement was for nurses to have more than one-year post qualification experience to meet the Agenda for Change band 5 criteria.

The agencies screened the nurses’ academic and professional documents in support of NMC Registration. The candidates, once shortlisted, were interviewed by appointing managers via video conferencing before a firm job offer was made. The trust then applied to the UK Home Office for approval of entry documents which were forwarded to the agencies in order for each successful candidate to apply for their working visa.

The nurses were supported professionally to pass relevant exams and gain registration as well as socially to settle into life in the UK and find a support network with established overseas nurses and
within the community. As a result, the trust had recruited close to 500 nurses which had helped to improve staffing numbers, particularly in medicine and urgent care, resulting in reduced use of agency staff and turn over and improved continuity of patient care.

In another area of innovation, the trust had developed an award winning proprietary Bedview system to give a trust wide view of patient information to improve decision making and patient safety and a proprietary Minestrone system linked to Bedview to maintain patient records.

The trust had some standardised improvement tools and methods, which were used by staff and the board. This encouraged staff to work together to resolve problems and to review individual and team objectives, processes and performance.

The trust had engaged with the Getting It Right the First Time (GIRFT) national programme and had a dedicated GIRFT team to support improvement. The trust had governance arrangements for oversight for the GIRFT program. The relaunched clinical effectiveness committee, which fed into the quality and performance committee, oversaw the GIRFT programme in the trust, to ensure effective implementation of GIRFT recommendations.

The trust had participated in several GIRFT reviews. Positive outcomes were identified in renal, cardiology and max-fax surgery. The trust's heart failure pathway was delivering above national average outcomes and had been recognised by the national GIRFT team.

We observed examples of changes made as a result from GIRFT recommendations and these were highlighted in policies, board papers and meetings. For instance, learning actions from the emergency department GIRFT review had been incorporated into the Portsmouth and South East Hampshire System Urgent Care Plan. In other examples, the data quality policy sited GIRFT values and the most recent integrated performance report reflected how GIRFT was being used to address improvements in stroke care after the Sentinel Stroke Audit highlighted areas for improvement.

The trust had begun to use a quality improvement program to identify and implement changes within the trust. For instance, the QI was highlighted in the winter pressures report with regard to reducing handover delays. The trust had adopted the Quality & Safety Improvement and Review (QSIR) methodology and had a number of accredited trainers in house.

However, this program was still embedding and the trust had not yet implemented a system wide approach. This was a strategic priority for 2020/21 and the trust planned to work with external experts on their QI program.

There were opportunities to share the results of improvement work, although there were no objectives to motivate or reward staff who identified and implemented improvements. For instance,
the Patient Safety conference in May 2019 included three-minute presentations from the leads on 20 recent quality improvement projects.

During the core service inspection, we observed that the trust celebrated #Fabchange Day to showcase QI work that had been completed in the trust under the #Fabchange Day banner. This encouraged staff to share information about changes where they had been undertaken. We also observed a meeting for patient research ambassadors where clinicians made brief presentations about their study or project.

There was effective participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service.

Learning was encouraged through internal, external and thematic reviews which take place throughout the trust. Learning was shared with staff and was highlighted throughout the trust’s monthly integrated performance report.

The trust had a serious incident review group which fed into the quality and performance committee and trust leadership team. It held a weekly incident review panel, chaired by the medical director, or his deputy, where incidents of significant harm or learning were reviewed and risk rated. Based on the risk rating and discussion the panel established the level of investigation required and made decisions about duty of candour and the required report, for instance if there would be an internal review that fed back internally and a full root cause analysis with an external investigator.

The trust had re-established the way that it reviewed deaths to ensure that all deaths were adequately reviewed and learning was taken and applied. The trust held daily mortality reviews which were held for all deaths (except in the Emergency Department, which had a separate process) to provide an immediate assessment of each death. The monthly mortality review group oversaw all elements of each death including hospital standardised mortality ratio, Dr Foster reports and outlier reports.

The monthly meeting was a multi-disciplinary meeting attended by the medical director, a non-executive director, a patient representative, and legal and clinical coding representatives, directors and consultants. This meeting provided visibility for any emerging trends and consistency in resolution. Minutes reflected that the meetings discussed themes as well as individual cases focusing on actions taken and learning identified.

The mortality review panel and group promoted learning from each death in the trust, including about how patients’ end of life care wishes were met. One example of this impact was the improved fast-track pathway to discharge when a patient was nearing the end of life.
The mortality review group fed into the quality and performance committee and submitted a ‘Learning from Deaths’ quarterly report to the board which was presented by the medical director.

The board recognised there were changes to the national context of deaths reviews which would require changes to their processes. However, the trust had reiterated its commitment to ensuring that the learning focus currently in place remained. To this end the trust had appointed a lead medical examiner with remaining medical examiner posts to be recruited. A business case for the Medical Examiners’ Officer had been compiled; this post was intended to be filled in December 2019.

The trust could provide examples of learning taken from coroners’ reports, external enquiries and action plans that were implemented after external reviews. The most recent medicines review focussed on oxygen safety which highlighted sub-optimal performance. This review prompted a QI project focusing on oxygen safety. As a result, the trust implemented training to improve the prescribing of oxygen and patient safety regarding oxygen. The trust plans to review patient outcomes and safety incident reports to evaluate the impact of the project.

There was however, a perceived disconnect between service lines and the pace of the business case approval process which had been acknowledged by the trust executive team and was being addressed.

Complaints process overview

The trust had a system for managing complaints and escalating them as necessary. The trust treated concerns and complaints seriously, investigated them and used the learning from complaints and concerns as an opportunity for improvement. However, the trust did not provide timely responses to complaints. More than half of the trust’s responses to complaints did not comply with the trust’s timeliness targets.

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</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>47%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>5,081</td>
<td>(June 2018 to May 2019)</td>
</tr>
</tbody>
</table>
Number of complaints made to the trust

From June 2018 to May 2019, the trust received a total of 730 complaints. The highest number of complaints were for outpatients, with 33.7% of the total complaints, followed by medicine (22.1% of complaints) and urgent and emergency services (19.2%).

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

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>246</td>
<td>33.7%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>161</td>
<td>22.1%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>140</td>
<td>19.2%</td>
</tr>
<tr>
<td>Surgery</td>
<td>96</td>
<td>13.2%</td>
</tr>
<tr>
<td>Maternity</td>
<td>34</td>
<td>4.7%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>22</td>
<td>3.0%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>17</td>
<td>2.3%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>10</td>
<td>1.4%</td>
</tr>
<tr>
<td>Critical care</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>730</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The board had oversight of the complaints process and progress. The complaints team followed a complaints policy which was in date and provided clear guidance. However, while the policy noted that complaints might be complex or non-complex, the target response time for all complaints was 30 days; it did not set a different timeliness target for the two types of complaint.

The CEO had oversight of each complaint and response, and signed each response letter.

The board reviewed complaints compliance monthly. The number of complaints and compliance with complaints KPIs was reported in the monthly Integrated Performance Report (IPR) to the board. The November 2019 IPR reflected that after several spikes in complaint numbers in the past year, there had been a decline in complaints since July 2019 and the complaint numbers for October 2019 were at their lowest point in the past year.

The director of governance and risk presented an annual complaints report to the Quality and Performance Committee which then recommended it to the board. The current report, which was...
to be discussed at the November 2019 board, reflected the quality of complaint responses had improved, with fewer requests for a second review and no referrals to the Parliamentary Health Service Ombudsman being upheld.

However, the report reflected that the timeliness of responses had declined. At the time of reporting the trust had met its 30 day target for only 27% of complaints; this had declined from the previous year’s performance and from performance numbers the provider submitted its Routine Provider Information Request (cited above).

The board papers reflected that the decline in performance was not acceptable. The papers further showed that the trust had implemented some mitigations, for instance bolstering the Patient Advise and Liaison Service (PALS). However, these mitigations did not yet appear to have had an impact on the timeliness of responses and trust had more work to do to meet its targets for timely responses to complaints.

We saw that when complaints were submitted they were risk reviewed and rated using a red, amber, green rating system. The complaints team worked with teams investigating incidents and Duty of Candour lead so that, where a complaint and incident were reviewed concurrently, these reviews were linked.

The trust generally reviewed complaints thoroughly and responded compassionately. We reviewed eight recently closed complaints to the trust. Seven of the complaints files reflected that complaints were risk reviewed and thoroughly assessed. All files reflected that complainants received a compassionate letter which outlined and answered their concerns and included an apology when an error had been made. Complainants were signposted to the Ombudsman to raise concerns, if they had any, about the complaint investigation.

However, with regard to one complaint reviewed, there was not a risk review or a thorough review of the underlying issues of the complaint and the team did not identify any specific learning from the complaint. This was not in line with the trust’s complaints policy and missed opportunities to learn.

Post complaint evaluations were sent to complainants. These responses were reviewed by the deputy director for governance and risk. The responses to these evaluations reflected that complainants were generally happy with the response to their complaint and felt listened to although they did not necessarily believe that their complaint would make a difference.

Compliments

From June 2018 to May 2019, the trust received a total of 4,987 compliments. The highest number of compliments were for medical care, with 40.1% of the total compliments, followed by maternity (30.4% of compliments).
A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>1,998</td>
<td>40.1%</td>
</tr>
<tr>
<td>Maternity</td>
<td>1,518</td>
<td>30.4%</td>
</tr>
<tr>
<td>Surgery</td>
<td>875</td>
<td>17.5%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>233</td>
<td>4.7%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>160</td>
<td>3.2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>147</td>
<td>2.9%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>56</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,987</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Accreditations**

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision was 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>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Anaesthesia Clinical Services Accreditation (ACSA): Annual return for May 2019 in production.</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and It's successor Medical Laboratories ISO 15189</td>
<td>Clinical microbiology, CPA accredited (Ref:0989 May 2014) Cellular pathology including diagnostic cytology, cervical cytology including HPV testing, histology (all areas), mortuary (reception, body storage and release) and Breast Sentinel Node Assay. Awarded October 2017.</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mortuary</td>
<td>Human Tissue Authority (HTA) licence The mortuary was inspected in two one day visits in August and November 2017 and final report issued (copy available on HTA website). HTA licence number 12237 continues to be in place.</td>
</tr>
<tr>
<td>Breast Screening Service</td>
<td>Implementation of a Quality Management System across the breast screening service which meets the requirements of ISO9001:2015 (accredited by BSI).</td>
</tr>
</tbody>
</table>

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

## Acute services

### Queen Alexandra Hospital

Southwick Hill Road  
Cosham  
Portsmouth  
Hampshire  
PO6 3LY  
Tel: 023 922 86000  
www.porthosp.nhs.uk

### Urgent and emergency care

**Facts and data about this service**

Urgent and emergency services are provided by the trust at Queen Alexandra Hospital. The department provides consultant-led emergency care and treatment from 08.00-24.00, seven days a week to people across the City of Portsmouth and south east Hampshire. The trust has a Minor Injuries Unit based at Gosport War Memorial Hospital and a GP-led Urgent Care Centre.

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

**Details of emergency departments and other urgent and emergency care services**

**Queen Alexandra Hospital**
• Accident and Emergency Department
• Paediatric Emergency Department
• Level 2 Trauma Centre
• Acute Medical Unit
• Ambulatory Emergency Care

Gosport War Memorial Hospital
• Minor Injuries Unit

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

Activity and patient throughput

From March 2018 to February 2019 there were 156,347 attendances at the trust’s urgent and emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at Portsmouth Hospitals NHS Trust compared to all acute trusts in England, March 2018 to February 2019

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.
Urgent and emergency care attendances by disposal method, from March 2018 to February 2019

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other outpatient services, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Our inspection was announced. We looked at the premises and equipment and observed care. The inspection team spoke with 10 patients and five relatives, approximately 30 members of staff including nurses, health care support workers, consultants, junior doctors, receptionists and domestic staff. We observed care and treatment and reviewed 12 patients' records. We reviewed information provided by the trust both before and after the inspection.
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 did not ensure all staff completed all required mandatory training.

Nursing staff did not keep up-to-date with their mandatory training. The trust set a target of 85% for completion of mandatory training. At the last comprehensive inspection in 2018, nursing staff had not met the trust’s mandatory training target. The findings during this current inspection did not show any significant improvement.

In urgent and emergency care the 85% target was met for nine of the 12 mandatory training modules for which qualified nursing staff were eligible. A breakdown of compliance for mandatory training courses from 01 April to 21 July 2019 at trust level for qualified nursing staff in urgent and emergency care was as below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>261</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>260</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>260</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>256</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>256</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>254</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>237</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>234</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>223</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>209</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>195</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>161</td>
</tr>
</tbody>
</table>

Medical staff did not keep up-to-date with their mandatory training. At the last comprehensive inspection in 2018, medical staff had not met the trust’s mandatory training target. The findings during this current inspection did not show any significant improvement.

In urgent and emergency care the 85% target was met for seven of the twelve mandatory training modules for which medical staff were eligible. A breakdown of compliance for mandatory training courses from 01 April 2019 to 21 July 2019 at trust level for medical staff in urgent and emergency care was as shown below:
### Safeguarding

Not all staff completed the trust's required safeguarding training. However, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Nursing staff received training specific for their role on how to recognise and report abuse. The trust set a target of 85% for completion of safeguarding training. However, information provided by the trust showed that nursing staff had not met the trust’s target for completion of all this training.

A breakdown of compliance for safeguarding training courses from 1 April to 21 July 2019 at trust level for qualified nursing staff in urgent and emergency care was as shown below:

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>104</td>
<td>108</td>
<td>96.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>104</td>
<td>108</td>
<td>96.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>104</td>
<td>108</td>
<td>96.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>104</td>
<td>108</td>
<td>96.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>101</td>
<td>108</td>
<td>93.5%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>101</td>
<td>108</td>
<td>93.5%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dementia Awareness (including Privacy &amp; Dignity standards)</td>
<td>95</td>
<td>108</td>
<td>88.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>89</td>
<td>107</td>
<td>83.2%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>87</td>
<td>108</td>
<td>80.6%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>79</td>
<td>105</td>
<td>75.2%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>72</td>
<td>107</td>
<td>67.3%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>65</td>
<td>107</td>
<td>60.7%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In urgent and emergency care the 85% target was met for four of the seven safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse. The trust set a target of 85% for completion of safeguarding training. However, information provided by the trust showed that medical staff had not met the trust’s target for completion of all
safeguarding training. This was a similar finding as at the last comprehensive inspection when medical staff had not met the trust target for completion of safeguarding training. A breakdown of compliance for safeguarding training courses from 1 April 2019 to 21 July 2019 at trust level for medical staff in urgent and emergency care was as shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>106</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>102</td>
</tr>
<tr>
<td>Safeguarding children (Level 3)</td>
<td>50</td>
</tr>
<tr>
<td>Prevent Basic awareness</td>
<td>184</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>92</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>137</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>61</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible.

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

However, despite the lack of completion of safeguarding training, discussions with staff demonstrated they had a good understanding about how to recognise abuse in both adults and children. This included the actions they needed to take if they suspected an adult or child had been subjected to or was at risk of abuse.

There was a children’s safeguarding lead nurse and an adult safeguarding lead nurse within the emergency department. Staff knew who they were and how to contact them. The safeguarding leads provided staff with update training. During the inspection, staff were released from the department to attend half-hour update children’s safeguarding training provided by the department’s children’s safeguarding lead nurse.

There were arrangements to safeguard adults and children at risk of radicalisation, domestic abuse and Female Genital Mutilation (FGM). The trust safeguarding policy referred to these issues and there were screening tools and referral pathways specifically for these concerns.

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. Staff did not always use control measures effectively to protect patients, themselves and others from infection. They kept equipment, but not all the premises visibly clean. The condition of some furnishing meant they could not be cleaned effectively.

Staff did not always follow infection control principles, including the use of personal protective equipment (PPE). During the inspection we observed staff practices that did not meet the trust’s infection and prevention policy and that did not protect patients from the risks of cross infection. We observed a member of staff removing used linen from a patient trolley/bed and carrying it across the department using no personal protective equipment such as gloves and aprons. They did not bring a dirty linen bag or trolley to the patient trolley/bedside. We observed some staff only wore gloves and not disposable aprons when attending to patients’ elimination needs. We observed a member of staff using their unprotected hands to open a bin lid, rather than using the foot pedal.
Cleaning staff were provided under a service level agreement with another provider. We observed practices from a member of the cleaning staff that presented a risk of cross contamination and risk to themselves: they were observed emptying bins without using any personal protective equipment.

Our review of the service’s infection prevention and control audits for July, August and September 2019 showed a staff compliance rate of 100% with infection prevention and control policies, except for hand hygiene before and after patient contact for September 2019 when the department scored 80%. This was below the trust’s target of 95%.

Not all areas were clean and had suitable furnishings which were clean and well-maintained. We saw there were used paper cups and used tissues on the floor of the reception waiting area where self-presenting patients waited to be attended to. The covers of some of the seating in the department’s x-ray area were worn and torn. This meant the seating could not be cleaned effectively and posed a risk of cross contamination for patients using this seating.

However, we observed some good infection prevention and control practices. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The department had side rooms to isolate patients who were infectious. Personal protective equipment, including disposable gloves and aprons, were readily available in all areas of the department. As part of the nursing handover, we observed infection prevention and control was included in a team building quiz.

We observed staff changed gloves and washed their hands between patient contacts. This was an improvement from the findings of our inspection in February 2019 and the department’s findings through a “sit and see” observation in August 2019, when it was identified staff did not change gloves between patient contacts.

Environment and equipment

The design, maintenance and use of facilities, equipment and premises did not keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment did not meet the needs and demands of the service. The emergency department was frequently crowded. Crowding in emergency departments is associated with an increase in mortality and impacts on patients’ experience. The emergency department comprised of a four-bay resuscitation area, with one bay designated for children. There were two major treatment areas; major treatment area A which had 18 bays and three side rooms; and major treatment area B which had 12 chairs, two bays and an additional bay for clinical examinations. There was one minor treatment area which consisted of care bays and one side room. There was a separate ‘pit stop’ assessment area with six trolleys and four chairs. The department had a nine-bed emergency decision unit which comprised of two four-bed bays and a single-bed side-room.

The emergency decision unit was used for patients who were unlikely to require admission, but who required short term observation or were waiting for test results before being discharged. The emergency decision unit was regularly used to accommodate patients with acute mental health problems who were waiting for assessment by a mental health practitioner or waiting for a mental health bed.

The designated room within the emergency decision unit that was used to accommodate patients with acute mental health problems had been adapted to reduce the risk of patients harming
themselves. The room did not fully comply with safety standards produced by the Royal College of Psychiatrists’ Psychiatric Liaison Accreditation Network (PLAN) because the room did not have two doors which opened both ways. However, risks were lessened because patients did not spend time unattended in this room.

Inspections of the urgent and emergency care service in 2018 and March 2019 had reported that crowding of the service posed risks to the safety of patients. At this current inspection, we found there was continued crowding of the department. The service had identified two areas of the department that could be used to cohort patients when there was no capacity for patients to be accommodated in the main emergency department areas. Cohort area one was the corridor area leading from the ambulance entrance to the pit stop and major treatment area B. Patients were accommodated on trolleys and there was dedicated numbered spaces for the trolleys. Cohort two was the waiting room for the department’s x-ray service. Staff removed the chairs from this area, which then accommodated up to four patients on trolleys or chairs. In both areas there were no call bells or piped oxygen and nowhere to safely secure patients’ records. Both areas were in use on all three days of the inspection in October and cohort area one was in use when we inspected on 12 November 2019. Staff told us that the cohort areas were open most shifts. The cohort areas did not support promotion of patients’ privacy and dignity. Patients allocated spaces in cohort area one, were in an area where there was constant traffic of staff, patients and relatives passing their trolley. Patients could observe other patients being wheeled in and out of the department, including patients seriously ill entering the resuscitation room.

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

The reception and waiting area for self-presenting patients was small and observed to be crowded on several occasions during the inspection. We observed that at times relatives who had accompanied patients to the department had to sit on the floor, because there was no available seating.

The children’s emergency department was co-located but physically separate, providing a secure area, which was not overlooked by adult patients and visitors. The trust told us the children’s emergency department was open from 7am to 2am. However, staff at the time of the inspection told us they had recruited sufficient numbers of nursing staff to enable the children’s emergency department to be open 24 hours a day. This meant that generally children did not have to be cared for in adult areas during the night, except for treatment in the dedicated children’s bay in the resuscitation room.

The children’s emergency department had a quiet room, that was used to accommodate children with mental health conditions while waiting for mental health assessments.

There was easy access to the co-located x-ray department and x-ray facilities were available in the resuscitation room. The CT and MRI scanning facility was not co-located and required patients to be escorted through the major treatment area into the main hospital if they required these scans.

Staff did not always carry out daily safety checks of specialist and emergency equipment. At the inspection of the service in March 2019 it was identified that staff did not always check resuscitation equipment in line with trust policy. Our review of emergency equipment checklists during this inspection identified, that although there had been improvements there were still some
gaps in the recording of checks of some emergency equipment. On 15 October 2019 we reviewed the records of daily checks for the cardiac arrest trolley in the major treatment A area. There was no record to show staff had checked the cardiac arrest trolley on 8 October 2019. There was no record to evidence staff had checked the transfer bag contents on 6, 7, 8 and 13 October 2019. On 15 October 2019 we reviewed the records of daily check lists for emergency equipment in the resuscitation area. Each of the four bays in the resuscitation area had emergency equipment and we found staff had not completed all daily checks of the emergency equipment in all bays for October 2019.

Not all patients could reach call bells. Patients cared for in the cohort areas did not have access to call bells to request assistance and help. To lessen risks to patients, a member of the nursing staff was allocated to each of the cohort areas to monitor and support their wellbeing. However, the nurse allocated to cohort one was also responsible for oversight of patients held in ambulances. At the inspection in 2018 it was noted that patients did not have access to call bells in all the toilet facilities. At this current inspection we observed toilet facilities had call bells.

The service had enough suitable equipment to help them to safely care for patients. For example, point of care testing was available within the emergency department enabling staff to reach clinical decisions without delay. For example, flu testing equipment resulted in confirmed cases of flu being diagnosed within 30 minutes. This enabled staff to better manage patients and to isolate them where this was clinically indicated.

The service employed a dedicated member of staff to coordinate the supply and maintenance of equipment. They worked in partnership with the trust’s central maintenance team to ensure servicing of equipment was carried out in a timely manner and in a manner that did not adversely affect the running and safety of the service.

Staff disposed of clinical waste safely. There were enough clinical and non-clinical bins and we saw most staff using these in a safe manner.

Assessing and responding to patient risk

Staff did not complete assessments for each patient in a timely manner. Arrangements for patients self-presenting at the department increased the risk of delays to assessment of their conditions and risk of deteriorating patients not being identified.

There was a risk of undetected deterioration of patients in the reception waiting area. There was a risk that patients self-presenting at the department with a time critical condition might not receive treatment within the required time scale. Staff did not always use tools to identify deteriorating patients to escalate them in a timely way. Initial assessments and ambulance handovers were delayed.

There was a risk of undetected deterioration of patients in the reception waiting area. There was no observable process that staff followed for monitoring the wellbeing and checking that patient’s conditions were not deteriorating in the reception waiting area. During three observation periods during the inspection of the emergency department on 15, 16 and 17 October 2019, we did not see staff carrying out any checks that patients in the reception waiting area were alright.

Staff did not monitor the condition of patients in the reception waiting area who were waiting for a care space in one of the major treatment areas. Following triage, some self-presenting patients were identified as needing assessment and treatment in one of the major treatment areas.
Patients who arrived by ambulance and required treatment in one of the major treatment areas were taken to an area known as the pit stop. The pit stop was staffed by a team of nurses and healthcare support workers 24 hours a day and between 8am and 12 midnight there was a senior decision-maker (consultant, registrar or consultant nurse). The team was responsible for undertaking an initial assessment and ordering appropriate investigations. When there was no capacity in the pitstop or other areas of the department, those patients were accommodated in the cohort areas, where staff were allocated to monitor the patients’ conditions, including hourly safety checks. However, for patients self-presenting who required assessment and treatment in the major treatment area, congestion in the department meant they had to wait in the reception waiting area. Although these patients were easily identifiable, as they were positioned in high backed red chairs along the back wall of the reception waiting area, there was no process to monitor these patients’ conditions to identify any deterioration because staff did not carry out hourly checks on these patients.

The length of time some patients spent in the reception waiting area increased the risk of undetected deterioration. Some patients spent several hours in the reception waiting area before being allocated a care space in the pitstop area, during which time staff did not monitor their conditions for risk of deterioration. On 16 October 2019 at 3.40pm the wait time for patients to be seen in pit stop, following triage was 6.5 hours, during which time staff did not carry out any checks on their condition. At the same time the wait time for the less sick patients to be seen in the minor treatment area was three hours. This meant staff treated the less sick patients before the sicker patients. The waiting times at 8.20am on 17 October 2019 were less, 2.5 hours to be seen in the pit stop and 45 minutes to be seen in minors. However, it was still the sicker patients who had to wait the longest to be seen and treated.

We raised this as an area of concern with the trust, who responded by allocating a health care support worker in the reception waiting area to monitor the safety of the patients, including repeating observations and completing safety check lists. We checked whether this change was improving the safety of patients during the well led inspection of the hospital. We carried out four periods of observation of the reception waiting area on 12 November 2019. We noted there was a health care support worker allocated to monitor the wellbeing of patients in this area. We observed that the health care support worker was introducing themselves to patients, checking on their welfare and offering drinks. We saw some examples of the health care support worker escalating patients to the navigator nurse. However, there were periods of time when there was no health care support worker presence in the area. This had a negative impact on patients and the risk of undetected deterioration of patients remained. One patient started coughing and looked like they were going to vomit, there was no member of staff present to attend to the patient. The CQC inspector had to find a member of staff to assist the patient.

There was a risk that patients self-presenting at the department with a time critical condition did not receive treatment within the required time scale. The trust did not measure how long self-presenting patients spent in the department before they were triaged (clinically assessed). Patients were booked in to the department only after they had been seen by the navigator nurse. It was only after they had been booked in that any monitoring of timelines of clinical assessment took place. The trust did not consider the length of time patients spent waiting to be seen by the navigator nurse and the length of time it took for them to be booked in at the reception desk.

Staff did not always use tools to identify deteriorating patients to escalate them in a timely way. Staff used the Early Warning Score (EWS) system to support the detection and response to clinical deterioration in adult patients. Staff used the Paediatric Early Warning Scores system to
support the detection and response to clinical deterioration in children. The electronic recording system used by staff automatically calculated the score for patients after the clinician entered the patient’s observations such as pulse rate, respiratory rate and blood pressure. The score alerted staff whether the patient’s condition was at risk of deterioration and the action they needed to take. The department’s processes required staff to carry out hourly observation and EWS scores on all patients allocated to a care space in the department. Our review of patient records during the inspection showed that for the days of the inspection most patients had their observation and EWS scores calculated hourly. However, the department’s own audits showed that for patients in the two major treatment areas and the resuscitation area, these scores were not always completed hourly.

Most patients told us staff checked and carried out observations on them regularly, this included patients in the cohort areas. However, one relative said they overheard members of staff discussing that because of workload, they had not been able to carry out patient observations hourly, with one member of staff saying that they had not been able to carry out any patient observations for three hours.

The Royal College of Emergency Medicine recommends that emergency department reception staff complete training to identify red flag signs and symptoms that may indicate a patient needed medical assistance. The reception staff that we had conversations with said they had received no such training. They said they would use their common sense to alert the navigator nurse if they thought a patient in the waiting area was looking unwell. However, they told us that when the reception desk was busy with patients booking in, they did not have a clear view of the waiting area.

The general overcrowding and lack of capacity in all areas of the emergency department presented a risk to patients receiving treatment in a timely manner. The trust’s review of incidents for the period January to March 2019 identified 970 incidents that referenced some element of overcrowding and four incidents that related to delays in treatment, including two delays of time critical treatment, due to lack of capacity within the department.

Initial assessments and ambulance handovers were delayed. The Emergency Department survey 2018, as detailed below, indicated that at that time patients views about the timeliness of the service was similar to that of other trusts. However, our findings from the inspection showed that initial assessments and ambulance handovers were delayed.

Emergency Department Survey 2018

The trust scored about the same as other trusts for the 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 A&amp;E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the A&amp;E department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in A&amp;E, did you feel threatened by other patients or visitors?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Median time from arrival to initial assessment (emergency ambulance cases only)

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

The Royal College of Emergency Medicine recommends that all patients should be assessed by a healthcare professional within 15 minutes of arrival. This standard was not consistently met. The median time from arrival to initial assessment was worse than the overall England median in all 12 months from July 2018 to June 2019 (ranging from 53 to 364 minutes). The England median over this period ranged from seven to nine minutes. The median recorded time to initial assessment during April 2019 was considerably lower than both the previous and subsequent months, at 53 minutes. The fact that there was such a sudden drop during April 2019 could indicate issues with the quality of the data submitted by the trust in this month. The trust told us they acknowledged they had a flaw in their date collection and reporting in this area and were working internally and externally to correct this problem.

Ambulance – Time to initial assessment from July 2018 to June 2019 at Portsmouth Hospitals NHS Trust

![Graph showing ambulance - time to initial assessment from July 2018 to June 2019 at Portsmouth Hospitals NHS Trust](Source: NHS Digital - A&E quality indicators)

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

Queen Alexandra Hospital

From August 2018 to February 2019 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Queen Alexandra Hospital. A gradual decrease in the percentage of ambulance journeys with turnaround times over 30 minutes was subsequently observed from February 2019 to July 2019.
Ambulance: Number of journeys with turnaround times over 30 minutes – Queen Alexandra Hospital

(Source: National Ambulance Information Group)
Ambulance: Percentage of journeys with turnaround times over 30 minutes – Queen Alexandra 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 7 May 2018 to 23 July 2019 the trust reported 3,632 “black breaches”, with an overall upward trend from November 2018 to April 2019.

Information provided by the trust following the inspection showed that there were still a significant number of patients waiting in ambulances over an hour before being handed over the emergency department staff. Between April 2019 and September 2019 there were a total of 2636 patients held in ambulances over 60 minutes.
At the inspections in 2018 and February 2019, patients were frequently held on ambulances outside the emergency department because there was no capacity to receive them in the department. At this current inspection we found this practice was still occurring. On each day of this current inspection we observed patients were held in ambulances because there was no capacity for them in the emergency department. Data provided for the period of our inspection of the emergency department showed that an average of 32.5 patients arriving each day at the department by ambulance had delays of handover to hospital staff of between 30 minutes to 60 minutes. For the same period an average of 42 patients each day had a delay of over 60 minutes for handover from ambulance staff to hospital staff. This showed it was still common practice for patients to be held on ambulances outside the emergency department.

When patients were held on ambulances, a hospital and ambulance liaison officer (HALO) from the NHS ambulance trust worked collaboratively. Patients were assessed by the emergency department nurse, who also had responsibility for patients in the cohort one area, as soon as the ambulance arrived in to the ambulance bay. Once a space became available, patients were offloaded, with the sickest patients given priority. The ambulance staff remained with the patient in the ambulance and provided the patient with ongoing care and monitoring.

The nurse allocated to the ambulance bay liaised with the ambulance staff to monitor the condition of the ambulance patients. If a patient's condition worsened, the ambulance bay nurse liaised with medical colleagues to review the patient and to treat the patient as clinically indicated. However, during the well led inspection carried out in November 2019, emergency department staff told us the ambulance staff took a ‘hands off’ approach once the patient was handed over to the hospital staff. This meant that although the nurse had a health care support worker working with them, their workload was often overwhelming. This meant there was a risk that changes in patient’s conditions would not be identified in a timely manner.

The department had two areas that they used to cohort patients when the department was above normal capacity. These were the corridor adjacent to the nursing station located at the
ambulance entrance and the department’s X-ray waiting room. There were strict criteria that had to be met for these two areas to be opened to patients. The criteria were detailed in the trust’s ‘Full Capacity Policy’, version 14 issued August 2019. This policy detailed the trust’s four full capacity escalation levels and the associated actions to support improvement in capacity and reduce risk to patients. This included the opening of the cohort areas in response to the numbers of patients attending the department and the number of patients being held in ambulances for over 30 minutes. We observed both cohort areas were open on all days of our inspection in October 2019 and one of the cohort areas was open when we inspected on 12 November 2019. Staff told us that it was usual for the cohort areas to be open.

There was risk that patients self-presenting at the emergency department were not assessed in a timely manner. Patients who self-presented to the emergency department were seen on arrival by a registered nurse, known as the navigator. Their role was to quickly assess patients (before they were booked in by receptionists) to direct them to the most appropriate area of the emergency department. This could be the minor or major treatment areas or if available the GP-led urgent care area. The clinical triage of patients was carried out by triage nurses after the patient had booked in at the reception area.

The waiting area for the navigator nurse was not overseen by the nurse and there was no process to ensure patients were seen by the navigator nurse in order of arrival. In addition, signs informing patients about what to do on arrival at the department were not always visible if the department was full. We observed patients on all days of the inspection go to the reception desk first, rather than sit in the waiting area for the navigator nurse. This meant there was a risk they would not be seen in order of arrival at the department. The introduction of a health care support worker, following our inspection in October 2019, to oversee patients in the reception waiting area, included monitoring of the navigator queue. However, our observations on 12 November 2019, showed this was not yet fully effective, with two patients being seen out of turn and patients having to sort the order of the queue out themselves.

To ensure patients were streamed in a timely manner, if there were more than four patients waiting to be assessed by the navigator, the navigator processes included an escalation process in which the navigator requested additional assistance to stream the patients.

There was a risk of lack of consistency in the streaming of patients self-presenting. There was no system or guidance to support the navigator nurse to make decisions about which part of the emergency department service patients should be directed to. We were told the navigator used their personal clinical knowledge to make decisions rather than following guidelines.

However, streaming and triage processes worked effectively in the children’s emergency department. There was a dedicated ambulance entrance area for the children’s emergency department. Children and young people were triaged immediately by the allocated children’s triage nurse. For children and young people self-presenting, they were sign posted at the main reception area to the children’s emergency department, where their conditions were assessed by the children’s triage nurse.

The triage process included assessment of patients for the possibility of sepsis. The electronic triage tool dictated actions, that followed the national sepsis 6 guidance, that staff needed to carry out and the care and treatment that needed to be provided to the patient if sepsis was suspected. The service audited their compliance with meeting the sepsis 6 process. Audits for the period April 2018 to June 2019 showed that although there was good compliance with screening patients for sepsis, the administration of antibiotics was not always carried out in a timely manner. However, the data showed there was improvement in the number of patients receiving intravenous antibiotics within an hour of diagnosis, with 76% of patients receiving antibiotics within an hour of diagnosis of sepsis during the period July to September 2019.
There was a lack of process to manage the skin integrity of patients. Patients remained on trolleys for long periods of time which increased their risk of developing pressure ulcers. The department staff used a nationally recognised tool to measure the likelihood of a patient developing a pressure ulcer. However, staff told us that this tool was only used once a patient had been in the department for six hours. This process meant staff did not consider that damage to skin integrity can occur within a short space of time, including prior to a patient being admitted to the emergency department. This practice increased the risk for patients of developing pressure ulcers, delayed actions to reduce the risk of patients developing pressure ulcers, delayed treatment of pressure ulcers, increased length of stay in hospital and increased morbidity due to the development of a pressure ulcer.

To ensure all staff understood the risks to the safety of patients and the action they needed to take to lessen that risk, the department had introduced the practice of safety huddles. These were held four times a day, or more frequently if there was increased acuity of patients and lack of capacity to allocate patients to care spaces. At the briefing issues that could impact on the safety of patients was discussed. This included staffing issues, vulnerable patients, patients waiting a long time to be seen, ill patients, capacity and patient flow problems. The safety briefing was attended by the nurse in charge, consultant in charge, the nurses in charge of the different areas of the department who then shared the information with the other staff on duty. The hospital manager attended one of the safety briefs to inform the emergency department about discharges through the trust, vacant beds and any safety issues affecting the rest of the hospital.

At the inspection in February 2019 we identified that there was little in the way of clinical leadership of the cohort areas and confusion among nursing staff as to which cohort patient posed the greatest clinical risk. During the current inspection we observed that the staff allocation each shift included a nurse to oversee the management of patients in cohort one (the corridor) and a dedicated nurse to manage and look after the patients in cohort two (x-ray waiting room). Nursing staff told us they assessed and monitored the wellbeing of patients in the cohort areas, including completing blood tests and some routine investigations. Medical staff told us, that if they had capacity, they attended to and started treatment for patients in the cohort areas.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, there was heavy reliance on bank and agency staff to maintain safe staffing numbers.

At the inspection in 2018 it was reported that the department had a plan to recruit additional nursing staff over the 12 months after that inspection. Data provided by the trust indicated some success with the recruitment programme, with the vacancy rate for qualified nurses decreasing and reliance on agency nursing staff decreasing. However, the service still relied on bank and agency staff to maintain safe nursing numbers. For example, on 17 October out of the five nursing staff working in the major treatment area A, three were agency staff. Staff told us that there was an average of 30% agency staff on duty each shift.

The staff escalation process included declaration of red flag incidents. A red flag incident was declared when there was a reduction in nursing workforce of over eight hours or more than 25% of the planned cover for that shift. The trust reported that there were 62 red flag staffing incidents in July 2019, 128 in August 2019 and 198 red flag staffing incidents in September 2019.

Management of the staff escalation processes included unfilled bank and agency staff shifts were filled with nursing staff who worked elsewhere in the hospital. The department had introduced a
process in which nurses who worked elsewhere in the hospital completed a shift shadowing the emergency department’s nursing staff. This was to dispel anxieties and concerns nursing staff may have about having to work a shift in the emergency department.

Staffing levels in the children’s emergency department met the Royal College of Paediatric Nursing standards by having two children’s nurses (child branch) on every shift. This meant the children’s emergency department was now able to open 24 hours a day seven days a week.

Trust level

The table below shows a summary of the nursing staffing metrics within urgent and emergency care at trust level compared to the trust’s targets, where applicable. Figures for qualified nursing staff were the same at both the trust and Queen Alexandra Hospital, therefore only the trust-level figures are presented below.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>570.3</td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>570.3</td>
<td>12%</td>
<td>13%</td>
<td>4.0%</td>
<td>34,673 (30%)</td>
<td>56,775 (49%)</td>
<td>25,545 (22%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>270.5</td>
<td>16%</td>
<td>18%</td>
<td>4.0%</td>
<td>34,673 (30%)</td>
<td>56,775 (49%)</td>
<td>25,545 (22%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover or bank use.

Following the inspection, the trust provided updated data for nursing staff, which showed that for the period November 2018 to October 2019, there was an upward trend in the turnover rate for nursing staff between May 2019 and October 2019. Additionally, there was a downward trend in the sickness rate for nursing staff between May 2019 and September 2019. Vacancy, bank and agency usage appeared to be stable.
Urgent and emergency care annual staffing metrics
November 2018 to October 2019

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff</td>
<td>588.3</td>
<td>13%</td>
<td>11%</td>
<td>3.6%</td>
<td>39,913 (36%)</td>
<td>48,270 (43%)</td>
<td>23,528 (21%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>274.3</td>
<td>14%</td>
<td>14%</td>
<td>3.9%</td>
<td>39,913 (36%)</td>
<td>48,270 (43%)</td>
<td>23,528 (21%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)
* Please note that sickness data was provided for the time period October 2018 to September 2019

Vacancy rates

The service had reducing vacancy rates.

Monthly vacancy rates over the last 12 months for qualified nurses shows a shift from December 2018 to May 2019, with vacancy rates falling (improving).

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

Sickness rates
The service had reducing sickness rates.

Monthly sickness rates over the last 12 months for qualified nurses show a downward trend from September 2018 to January 2019.  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Following the inspection, the trust provided updated data for nursing staff, which showed that for the period November 2018 to September 2019, there was a downward trend in the sickness rate.

Agency staff usage

The service had reduced the use of bank and agency nurses, although staff reported there were always agency nurses on duty.
Monthly agency hours over the last 12 months for qualified nurses shows a shift from December 2018 to May 2019.  
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, the service relied on consultant medical staff working additional hours to deliver a safe service.

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

There were continuing concerns about medical staff cover at night. Senior medical cover was provided at night by a registrar or middle grade doctor, supported by a consultant on call. Consultants felt obliged to stay late to support their more junior colleagues. Staff we spoke with, including consultants told us they routinely remained at work over their rostered hours until 2am to 4am to provide clinical support for their colleagues. It was reported to us that the consultant rotas were now set around the normalised practice of consultants working over their rostered hours.

Junior doctors all commented positively about the support provided by the senior medical team.

Trust level

The table below shows a summary of the medical staffing metrics within urgent and emergency care at trust level compared to the trust’s targets, where applicable. Medical staffing metrics are the same at both trust level and at Queen Alexandra Hospital.
<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>570.3</td>
<td>12%</td>
<td>13%</td>
<td>4.0%</td>
<td>14,280 (30%)</td>
<td>1,280 (3%)</td>
<td>31,448 (67%)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>117.4</td>
<td>3%</td>
<td>7%</td>
<td>1.1%</td>
<td>15,277 (54%)</td>
<td>1,421 (5%)</td>
<td>11,560 (41%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use or agency use.

Following the inspection, the trust provided updated data for medical staff, which showed that for the period November 2018 to October 2019 there was a downward trend in agency staff usage from May 2019 to October 2019. No indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness or bank use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

* Please note that sickness data was provided for the time period October 2018 to September 2019
Staffing skill mix

In May 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.

Staffing skill mix for the 47 whole time equivalent staff working in urgent and emergency care at Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>38%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>13%</td>
<td>21%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

Records

Staff did not always keep detailed and up-to-date records of patients’ care and treatment. There was no process to monitor staff completion of patient records. However, records were stored securely and easily available to all staff providing care.

At the previous comprehensive inspection in 2018 we found that staff did not consistently keep appropriate records of patients’ care and treatment: safety check lists were not always completed; initial assessment cards were not always fully completed; and there was a lack of auditing of patient records.
At this current inspection the service told us the emergency department did not complete documentation audits in the same way that the trust did for inpatients. Daily audit of the transfer checklist audit was discontinued in April 2019 because results were consistently at a high level. However, there was now no process to monitor the standard of completion of transfer check list remained at that high level.

The trust told us there were plans to develop a monthly departmental audit tool like the inpatient documentation audit. However, at the time of inspection this was not in place. The only parts of patient documentation that were audited were the number of triage forms completed, the number of observation forms completed, the number of safety check lists uploaded, and the number of safety check lists completed.

The trust provided us with data for completion of triage and observation forms for three weeks in October 2019. This showed there was poor completion of patient triage forms, with an average completion rate of 53%. The data provided for completion of observation forms showed that staff compliance with completion of observation charts for the minor treatment area and paediatric emergency department was 88%. The data for the major treatment areas and resuscitation area indicated a compliance rate of 27% for the three-week period.

The trust provided us with data about completion of safety checklists for July, August and September 2019. An audit of 15 sets of patient checklists across the major treatment areas A and B, and resuscitation area was completed three times a day. The data provided showed staff compliance with completion of the safety check lists did not meet the trust target of 85% in any of these three months. The completion rate in July 2019 was 81%, August 2019 75% and September 2019 the completion rate was 84%. Narrative on the audit reports indicated that although the audits were only carried out in certain areas, the audit of records included the time patients spent in the pitstop area.

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

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Medicines, including controlled drugs were appropriately stored in secure areas. Suitable emergency medicines were available, stored appropriately and regularly checked. Medicines stored in fridges were stored at the correct temperature at the time of our visit and records confirmed that staff completed temperature checks. There was evidence to show that when temperatures were found not to be in the correct range, appropriate action had been taken.

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

There was a process for identifying high risk and time-critical medicines on the patient records system when patients were booked into the emergency department. Alerts were added to patients’
records so that nurses were prompted to administer patients ongoing medicine’s while they were in the department. This process had been further developed with the introduction of a green coloured wrist band worn by the patient, that indicated to staff they needed time critical medicine, such as medicine to manage Parkinson’s disease.

To ensure nursing staff were alerted to any new medicines prescribed for patients, the service had introduced a peg system. Once the medical staff had prescribed a medicine for a patient, they attached a peg to the outside of the patient’s paper records. This meant nursing staff could easily identify if a change had been made to the patient’s prescription and administer the medicine.

**Incidents**

*It was not clear that all staff recognised and reported all incidents and near misses.* Managers had not ensured that actions from patient safety alerts were implemented and monitored. 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 we had conversations with had an understanding about how to report incidents and what type of incidents they needed to report. Our review of incidents reported in October 2019, showed that both incidents and near misses were reported. The incident reports gave detail about initial actions taken to reduce risks of similar occurrences.

However, it was notable that there were only three incidents or near misses relating to the reception waiting area. Two were about patients not being booked in correctly and therefore not having their condition assessed in a timely manner and the third was about staff reviewing old test results rather than recently completed test results for a patient. Overcrowding, relatives having to sit on the floor, delays of patients being clinically assessed and patient queue jumping for the navigator nurse were not reported as incidents, suggesting that staff considered these as normal practices. The lack of oversight of patients in the reception waiting area increased the risk of incidents not being recognised and reported.

Staff confirmed they received updates and learning from incidents that occurred both in the department and across the trust.

**Never Events**

From August 2018 to July 2019, the trust reported two never events for urgent and emergency care. These occurred in December 2018 and February 2019. On both occasions a patient was connected to an air flowmeter instead of oxygen.

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.

(Source: Strategic Executive Information System (STEIS))
Our review of incidents and review of the investigation report for the never event that occurred in February 2019 showed there had been a total of three incidents of patients being connected to an airflow meter instead of oxygen, two of them occurring in December 2018. The first never event in December 2018 had not initially been reported and was only reported when the same member of staff observed a second patient had been attached to an airflow meter, rather than oxygen. There was a delay in declaring these incidents as a never event as the reporting staff did not recognise it as a never event.

These three repeated incidents indicated that the service had not fully considered a patient safety alert about reducing the risk of oxygen tubing being connected to airflowmeters. This alert was published in October 2016 and required all hospitals providing NHS funded care that supply medical air using a medical gas pipeline system to remove airflow meters or fit them with caps by July 2017.

The incident investigation identified that there had been no oversight of the response to the patient safety alert and that staff had not known that a patient connected to an airflow meter instead of oxygen was a never event.

During the inspection we observed that all air inlet pipes were capped off to reduce the risk of a similar occurrence.

**Breakdown of serious incidents reported to STEIS**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2018 to July 2019. A breakdown of incidents by incident type are below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
<td>28.6%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>2</td>
<td>28.6%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>2</td>
<td>28.6%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Staff understood the duty of candour, that they needed to be open and transparent, and give patients and families a full explanation if and when things went wrong. However, we were not provided with any examples where duty of candour had been followed.

**Safety thermometer**

**Staff collected safety information and shared it with staff.**

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 the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported two new pressure ulcers, 11 falls with harm and nine new urinary tract infections in patients with a catheter from August 2018 to August 2019 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Portsmouth Hospitals NHS Trust

![Graphs showing prevalence rates](image)

Insert commentary on any trends.
1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Safety thermometer detail was displayed in the staff rest room, so all staff were aware of the results. The information was not displayed in the public facing areas of the department, which meant public and patients were not informed of these results.

Is the service effective?

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

**Nutrition and hydration**
Staff did not have assurance that patients had enough food and drink to meet their needs and improve their health. However, they did consider the needs of patients who needed special feeding and hydration techniques.

We observed staff offered patients in the emergency department, including those waiting in the cohort areas, drinks and food. However, patient records did not evidence whether patients had anything to eat or drink only that staff gave them a bottle of water or a packet of sandwiches. Other than for patients who received intravenous fluids as part of their treatment, staff did not monitor or record patient's fluid intake.

For patients who self-presented and were waiting in the reception area, there were drink and refreshment machines they could purchase food and drinks from. The reception area did not have a water dispenser for patients to use, instead they had two small water jugs and plastic glasses that patients could use.

The service considered the needs of patients who had swallowing difficulties. The stroke link nurse had recently sourced thickened drinks for patients who had swallowing difficulties and they were facilitating training for several nurses to equip them with skills to assess patients swallowing reflexes.

**Emergency Department Survey 2018**

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

*(Source: Emergency Department Survey, published 2019)*

**Pain relief**

Staff assessed and monitored patients to see if they were in pain and gave pain relief. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff monitored patients’ pain levels as part of the hourly safety checks and administered pain relieving medicines as required. Patients that we had conversations with said that their pain was well managed, and staff gave them pain relieving medicines when they needed it.

We observed that information about assessing pain in patients who were not able to communicate their needs, such as patients living with dementia, was displayed in some areas. This included the use of a nationally recognised tools for assessing pain.
Emergency Department Survey 2018

In the CQC Emergency Department Survey, the trust scored 7.3 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.

(Source: Emergency Department Survey, published 2019)

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make some improvements to achieve good outcomes for patients.

We were not assured that managers and staff used audit results to improve patients’ outcomes. The service participated in relevant national clinical audits. These included the Royal College of Emergency Medicine (RCEM) audits that were specific to the delivery of urgent and emergency care. However, the national audit results for 2017/18 showed the service did not meet any of the RCEM national standards for clinical management of severe sepsis and septic shock, moderate and acute severe asthma and consultant sign off. During the inspection we asked the senior leadership team about the actions they had taken to address the findings of these audits and make improvements. They commented, that as the audit lead was not available they did not have the information to inform us about actions they had been and were taking. They did not reflect on how the findings from the audits had influenced how they delivered their clinical work to meet the needs and improve outcomes for patients.

However, information the service provided us, did demonstrate they were acting to improve the screening and management of sepsis. Service led audits during the period June 2018 to March 2019 showed a compliance rate of 98% with sepsis screening. Service led audits showed the number of patients receiving antibiotics within an hour of arrival had improved, with an average of 76% of patients receiving antibiotics within an hour of diagnosis of sepsis during the period July to September 2019. The emergency department also had an action plan they were following to improve the management of sepsis, which included the use of a sepsis triage tool and increased sepsis training on the unit for all staff.

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Queen Alexandra Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for 1 standard:

- Standard 5: Blood cultures obtained: Within one hour of arrival

The department was in the lower UK quartile for 1 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 department’s results for the remaining 6 standards were all within the middle 50% of results.

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or
involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department.

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival.

- Standard 4: Serum lactate measured within one hour of arrival.

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival.

- Standard 7: Antibiotics administered: Within one hour of arrival.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival.

List of standards in this audit that are agreed for inclusion in inspection reports:

- 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. This department: 16.8%; UK: 69.1%.

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 58.4%; UK: 64.6%.

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 29.0%; UK: 30.4%.

- Standard 4: Serum lactate measured within one hour of arrival. This department: 65.0%; UK: 60.0%.

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 69.7%; UK: 44.9%.

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 34.3%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 32.7%; UK: 44.4%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 14.0%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Queen Alexandra Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for 0 standards.
The department was in the lower UK quartile for 2 standards:
- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department.
- Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy

The department’s results for the remaining 5 standards were all within the middle 50% of results.
- Standard 1a: oxygen should be given on arrival to maintain oxygen saturation levels of 94-98%
- Standard 2a: Vital signs should be measured and recorded on arrival at the emergency department.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible:
  - 5a: Within one hour of arrival (acute severe)
  - 5b: Within four hours (moderate)
- Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines

List of standards in this audit that are agreed for inclusion in inspection reports:
- Standard 1a (fundamental): Oxygen should be given on arrival to maintain oxygen saturation levels at 94-98%. This department: 28.0%; UK: 19%.
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 38.0%; UK: 26%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 8.7%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 63.2%; UK: 77%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone orally or 100mg hydrocortisone intravenously
  - Children 6-15 years: 30-40mg prednisolone orally or 4mg/kg hydrocortisone intravenously
  - Children 2-5 years: 20mg prednisolone orally or 4mg/kg hydrocortisone intravenously
  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 20.9%; UK: 19%.
  - Standard 5b (fundamental): within 4 hours (moderate). This department: 23.3%; UK: 28%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
  - This department: 39.6%; UK: 52%.

(Source: Royal College of Emergency Medicine)
RCEM Audit: Consultant sign-off 2016/17

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

The department was in the upper UK quartile for 1 standards:
- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over.

The department’s results for the remaining 3 standards were all within the middle 50% of results.
- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over.

List of standards in this audit that are agreed for inclusion in inspection reports:

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

Standard 2 (developmental: Consultant reviewed: fever in children under 1 year of age. This department: 12.0%; UK: 8%.

Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 8.0%; UK: 12%.

Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 8.0%; UK:10%.

(Source: Royal College of Emergency Medicine)
Trauma Audit and Research Network (TARN)

The service did not meet the national standard for crude median time from arrival to CT scan of the head for patients with traumatic brain injury and crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care which would increase the risk of these patients having a poor outcome from their injury.

Queen Alexandra Hospital

The table below summarises Queen Alexandra Hospital’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Ascertainment (Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</td>
<td>89.5 – 100+%</td>
<td>Good</td>
<td>Met</td>
</tr>
<tr>
<td>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury (Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</td>
<td>72 mins</td>
<td>Takes longer than the TARN aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury (Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</td>
<td>100.0%</td>
<td>Higher</td>
<td>N/A</td>
</tr>
<tr>
<td>Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care (Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</td>
<td>0.0%</td>
<td>Lower than the TARN aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Risk-adjusted in-hospital survival rate following injury (This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</td>
<td>0.7 additional survivors</td>
<td>Similar to expected</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: TARN)
Following the inspection, we asked the service for information about the RCEM audit 2018 and associated action plans. The service provided information about the findings and actions they were taking in response to RCEM audits carried out in 2017/18. The RCEM fractured neck of femur audit, published in May 2018, found that the trust performed better than the national average for assessing patients’ pain within 15 minutes of arrival, ambulance notes being available and patients with a higher pain score receiving pain relief quicker than those patients with a lower pain score. However, the audit found the following areas that needed improving: only half of patients were offered analgesia within an hour; there had been a steady fall in the number of patients receiving pain relief within the first hour of arrival in the department; there was documented re-evaluation of pain score in only 40% of patients. The service had an action plan to address these findings and improve patient outcomes, which included the introduction of fascia iliaca blocks.

The RCEM National Audit Pain in Children 2017 – 2018, published in May 2018, found the following areas of good practice; the service performed better than the national average in assessing children’s pain with 15 minutes of arrival in the department; the service performed better than the national average and above the RCEM target for patients in severe pain receiving appropriate pain relief within 20 minutes of arrival or triage; the service performed better than the national average and above the RCEM target for patients with moderate pain receiving appropriate pain relief in accordance with local guidelines. However, the audit found the following areas that needed improvement: not all children and young people received pain relief analgesia within the target of 60 minutes; there was no documented evidence that children and young people with severe or moderate pain had their pain re-evaluated within 60 minutes of initially receiving pain relief. The service had an action plan to address these finding and improve outcomes for children and young people, which included the introduction of a pain passport.

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

The service had a higher (worse) than expected risk of re attendance within seven days of initial attendance than the national standard, but had performed better than the England average.

From July 2018 to June 2019, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5%, but lower than the England average over this period.

**Unplanned re-attendance rate within seven days - Portsmouth Hospitals NHS Trust**
**Competent staff**

The annual appraisal rates still did not meet the trust’s target. However, managers held supervision meetings and offered development support for staff and gave all new staff a full induction tailored to their role before they started work.

The nurse practice educators supported the learning and development needs of staff. There were two nurse practice educators. They described to us a comprehensive in-house training programme for nurses and a structured approach to developing band five nurses, using a competency framework. There were twelve in-house study days, which included all essential role-specific competencies, including training in use of equipment. The practice educators reviewed incidents to identify areas that staff needed additional support and training. The practice educators were in the process of completing a training needs analysis for the department, which was due to be completed at the end of November 2019. They intended to use this information to plan the education programme for the following year.

Managers gave all new staff a full induction tailored to their role before they started work. All new nursing staff completed an induction programme. The length of time for induction was dependant on the experience of the new member of staff and ranged from four weeks for an experienced nurse to six weeks for a newly qualified or international nurse. During the induction period the member of staff worked in a supernumerary role. The supernumerary role was continued for overseas nurses while they waited for registration with the Nursing and Midwifery Council.

Junior doctors received two hours of protected training time each week, regardless of the pressure in the department. They told us consultants offered excellent support. We observed good informal teaching sessions led by consultants during staff handover sessions. The service provided multidisciplinary simulation training.

Clinical educators supported the learning and development needs of medical staff. The department had some consultants working in the role of clinical educators. This was a role that was part funded by National Health Service England (NHSE) and part funded by the trust and provided dedicated practical educational support to junior medical staff working in the department.

There was an advanced care practitioner programme and the department was extending the use of this role in the department.

(Source: NHS Digital – A&E quality indicators)
The department worked closely with the military nursing and medical staff and had an agreement for the military to take over the running and staffing of the department three days a year. This released all the emergency department to staff to attend whole day training.

**Trust level**

From June 2018 to May 2019, 82.4% of staff within the urgent and emergency care department at the trust received an appraisal compared to a trust target of 85%. Although this figure did not meet the trust target of 85%, it was an improvement from the figure of 56% completion of appraisals in the 2018 inspection.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2018 to May 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>109</td>
<td>112</td>
<td>97.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>76</td>
<td>91</td>
<td>83.5%</td>
<td>85%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>70</td>
<td>84</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>189</td>
<td>252</td>
<td>75.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>444</strong></td>
<td><strong>539</strong></td>
<td><strong>82.4%</strong></td>
<td>85%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Nursing staff we had conversations with told us they received annual appraisals and group or individual supervision, which included review of the support they needed to progress their career and development. However, the data provided by the trust showed completion of annual appraisals for nursing staff still did not meet the trust target of 85%. A structured process for carrying out annual appraisals and supervision had been put in place. Staff were allocated to teams, with a band seven nurse leading the team and coordinating the appraisals and supervision of nursing staff in their team.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff, teams and services worked well to deliver effective care and treatment. At the inspection in 2018 the trust had developed an Acute Admissions Standard Operating Procedure. The procedure set out the appropriate admission routes for patients with identified acute illnesses. The procedure also clarified that the responsibility for the ongoing care of these patients, once referred, lay with the admitting specialty, regardless of the location within the hospital of the patients. There were internal professional standards displayed in the major treatment areas, which reinforced that specialty clinicians were expected to review patients in the emergency department within 60 minutes. At this inspection staff reported this process was working well. However, the effectiveness of this process was not formally monitored or reported on.
Most referrals from the emergency department were to the acute medical or surgical specialty teams. Medical admissions were usually via the acute medical unit and the acute medical unit physicians were visible in the emergency department when it was under pressure.

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

The frailty team consisted of geriatricians, doctors, community nurses, older persons nurse specialists, physiotherapists, occupational therapists and health care support workers. There were also links with social workers from two local authorities and the hospital’s dementia case workers. The team worked well and proactively with other disciplines throughout the hospital and wider community with the aim to deliver effective care and achieve better outcomes for older people.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Staff had good access to a 24-hour seven-day psychiatric liaison team for patients aged 16 and above. There was improved access to mental health services for children and young people, with a child and adolescent mental health services (CAMHS) available between 4pm and midnight seven days a week.

There was close collaborative working with the local NHS ambulance trust. This included the secondment of a paramedic from the ambulance trust to work as part of the emergency department’s quality improvement team looking at improving the patients’ journey from arrival at the department.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

There was access to radiology services seven days a week, with rapid access to CT scanning facilities.

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

There was paediatric mental health support from a local mental health NHS trust CAMHS team 4pm to 10pm seven days a week. The timing for the delivery of this service had been decided by reviewing the timings when there was demand for the CAMHS service.

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

**Health promotion**

**Staff gave patients some support and advice to lead healthier lives.**

Health education leaflets were available for patients in the minor treatment area. Health education posters were displayed in the reception waiting area.

Patients were empowered to manage their own health. Staff told us they offered advice to patients about stopping smoking and general lifestyle guidance.
National priorities to improve the population’s health were sometimes supported. We saw posters displayed in the department giving information about alcohol dependency. However, we saw no evidence of support provided around drug misuse, obesity or cancer risks.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

**Mental Capacity Act and Deprivation of Liberty training completion**

**Trust level**

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from 01 April 2019 to 21 July 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>01 April 2019 to 21 July 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td></td>
<td>259</td>
<td>262</td>
<td>98.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td></td>
<td>225</td>
<td>261</td>
<td>86.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was met for both MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from 01 April 2019 to 21 July 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>01 April 2019 to 21 July 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td></td>
<td>97</td>
<td>107</td>
<td>89.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td></td>
<td>75</td>
<td>107</td>
<td>70.1%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff demonstrated in conversations a good understanding about their responsibilities towards the Mental Capacity Act 2005. We observed staff explaining and seeking patients verbal consent before carrying out episodes of care or examinations.

Medical staff had a good understanding of the Do Not Attempt Cardiopulmonary Resuscitation decision process. A junior doctor described how he was supported by a consultant to carry out a Do Not Attempt Cardiopulmonary Resuscitation decision process, considering the patient’s wishes and capacity to understand the decision being made.
Staff had an understanding about the Mental Health Act. There were process and procedures in place to help staff support patients with mental health needs, including taking account of their responsibilities towards the Mental Health Act.

Is the service caring?

Compassionate care

Staff did not always treat patients with compassion and kindness or respect their privacy and dignity.

We saw most staff in different roles interacted with patients in a kind, respectful and considerate way. However, we observed some behaviours that did not demonstrate compassion and kindness towards patients. On one occasion we saw the navigator nurse did not come out of the navigator room when calling for the next patient to be assessed. They just called out from the room, ‘who’s next?’ They did not consider whether the patient needed any help or support to enter the navigation room.

A patient in the reception waiting area told us that they felt staff were matter of fact and did not display any kindness. They said, “when you are feeling so ill, you just want someone to be kind to you.”

Patients’ privacy and dignity were not always respected. On one occasion we observed staff did not promote privacy for a patient’s elimination needs. The patient had to use a urine bottle in the cohort one (corridor) area, with no screening to protect their privacy and dignity. All patients on trolleys in the cohort areas were provided with blankets to protect their modesty. However, staff did not always act to protect patients’ dignity when blankets were not covering the patients. We observed an occasion when a blanket had come off a patient and they were exposing parts of their body. Several trust staff walked past and took no action. It was a paramedic from the ambulance trust who attended to the patient and replaced their blanket.

Staff did not consider or act to protect patients in the cohort areas from the lack of privacy and dignity due to the constant traffic of staff, patients and relatives passing their trolley.

During our observation of the reception waiting area on 12 November 2019 there were periods of time when the health care support worker was not present in the room. We saw incidents where this impacted on the dignity of patients. One elderly patient asked a passing nurse for assistance to the toilet. The nurse said they would return, but did not. The patient had to struggle to walk to the toilet with the assistance of one of the other patients in the waiting area. There was no member of staff available to provide support and compassionate care to another patient who was feeling sick.

However, when patients moved between areas of the department we observed staff made eye contact and informed patients about where they were being moved to. This was an improvement from the last comprehensive inspection in 2018. Receptionists who greeted patients who self-presented to the emergency department were polite, and attentive. We saw porters interacted with patients in a friendly way.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended)
was about the same as the England average from June 2018 to May 2019.

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

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Response rates for Portsmouth Hospitals NHS Trust from June 2017 to May 2019 are shown below.
Portsmouth Hospitals NHS Trust – response rate June 2017 to May 2019

The chart below shows the mean friends and family test positive recommendation scores, with upper and lower control limits. The width of the control limits are based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data.

The trust scored between 85.9% and 96.3% from June 2017 to May 2019.

The graph below shows that from May 2018 to May 2019, there was a shift in the mean Family and Friends test score outside of the control limits. This downward shift also coincided with an increase in the response rate to the friends and family test.

(Source: Friends and Family Test – NHS England)

This data indicated that patients were less satisfied than they had previously been with the service they received from the emergency department. Information received from patients and relatives
prior to the inspection in the form of enquires to CQC, indicated a general level of dissatisfaction with the length of time patients had to wait to be seen in the department and lack of provision of information. However, most feedback from patients we spoke with during our inspection was positive. Most commented about how busy staff were, but also said they had received the attention and care they needed, and that staff were friendly and helpful.

### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**

At the last comprehensive inspection in 2018 we identified that staff did not always provide patients with the emotional support they needed. At this current inspection we found most staff were mindful of the emotional support patients needed. Most patients we had conversations with said they felt staff were kind and addressed their concerns and worries.

We saw staff involve both patients and those close to them in their own care, allowing time to answer any questions.

Staff explained that relatives or carers wishing to stay with a loved one in the resuscitation areas could be accommodated if appropriate. There were arrangements in place to support relatives of bereaved patients. A full chaplaincy service was available for patients and relatives; staff could contact religious leaders from a range of denominations.

### Understanding and involvement of patients and those close to them

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Patients and relatives, we had conversations with said that despite staff being very busy, staff kept them informed about what was happening and their treatment.

Staff supported patients to make informed decisions about their care. Patients told us staff included them in making choices about their care and treatment and we observed that happening in practice.

### Emergency Department Survey 2018

The feedback from the Emergency department survey was mixed.

The trust scored about the same as other trusts for all the 24 Emergency Department Survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2018</th>
<th>2018 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you informed how long you would have to wait to be examined?</td>
<td>3.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. While you were waiting, were you able to get help from a member of staff to ask a question?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. Did you have enough time to discuss your condition with the doctor or nurse?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2018</td>
<td>2018 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Q14. While you were in A&amp;E, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. While you were in A&amp;E, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall, did you feel you were treated with respect and dignity while you were in A&amp;E?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Before you left A&amp;E, did you get the results of your tests?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. If you did not get the results of the tests when you were in A&amp;E, did a member of staff explain how you would receive them?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>N/A</td>
<td>Not applicable</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>5.2</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 A&amp;E?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?</td>
<td>6.4</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 A&amp;E?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Did staff give you enough information to help you care for your condition at home?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q46. Overall... (please circle a number)</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey, published 2019)
Is the service responsive?

Service delivery to meet the needs of local people

Facilities and premises did not meet the needs of the number of patients attending the department. Demand for services frequently outstripped the availability of appropriate clinical spaces to assess, treat and care for patients.

Managers were not able to adequately plan and organise the service to meet the needs of the local population, demand for the service outweighed capacity. However, there were plans underway for a redevelopment of the service. As part of the redevelopment the service was reviewing patient pathways throughout the trust to design an emergency department that would meet the needs of patients and support effective access and flow to the department and the rest of the hospital.

Meanwhile patients frequently queued in the corridor in the emergency department, where it was difficult to maintain their comfort, privacy and dignity. During our inspection we saw patients queuing on trolleys in the cohort area one, just inside the ambulance entrance to the emergency department and next to the pit stop area, where patients had no privacy. An overflow room, known as the star suite, with two curtained bays was used by staff to carry out examinations such as ECGs and taking blood samples for the patients in the cohort area which gave patients some privacy during examinations and procedures. The room was also used by ambulance crews to transfer patients from their stretcher to a hospital trolley. Cohort area one was open on all three days of our inspection in October 2019 and on 12 November 2019 when we carried out further observations of the department. The additional cohort area, (cohort area two), was also open the three days of inspection in October 2109, but was not open on 12 November 2019. When the department became very congested, patients were assessed on ambulances as there was no space in the ambulance entrance.

Patients did not have access to call bells in the cohort areas. There was one nurse, responsible for taking handover from arriving ambulance crews, as well as observing patients in cohort area one. This meant there was a risk that the patients in cohort area one, would not have their needs met as, without a call bell, they would not be able to alert staff to their needs. Cohort area two had a dedicated nurse to that area, who had no other patients to observe or care for, so patients’ needs in this area were more likely to be met.

During our inspection we saw the waiting area for patients who self-presented to the emergency department was cramped, with all seating full and some patients having to stand, and at times relatives having to sit on the floor. There was access to toilets, accessible to wheelchair users. All toilets we viewed had pull cord alarms to allow a patient to summon assistance.

Although there were signs to direct self-presenting patients to wait in a dedicated area of the reception waiting room to be seen by the navigator nurse before booking in at the reception, we frequently saw patients who were unsure what to do or where to sit on arrival.

Patients were screened by the navigator, a registered nurse, who was stationed in a glass-screened room. The door was kept open, which did not allow for patient privacy. However, when we observed the process we saw that conversations were undertaken with sensitivity to patients’ confidentiality.
The children’s area was a securely accessed area, audio and visually separate from the main adults’ area. It was sensitively decorated, furnished and equipped with toys and there was a separate area for teenagers.

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

There was a relatives’ room in the emergency decision unit. This room had comfortable seating and access to a toilet and tea and coffee making facilities.

Since the last comprehensive inspection, following fundraising activities, a bereavement suite had been opened. This was in the emergency decision unit. It allowed grieving relatives to spend time in a comfortable and calm environment and allowed them to spend time alone with their deceased family member.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs. Staff coordinated care with other services and providers.

The service took account of the individual needs of patients and had taken some steps to support patients in vulnerable circumstances and those with complex needs.

Staff supported patients living with dementia. There was an identified dementia champion in the emergency department. Staff had limited access to specific equipment such as ‘twiddle muffs’ which provide distraction and meaningful activity for patients living with dementia. This was due to damage to their previous equipment from a water leak. The service was taking steps to increase their stock of such equipment. Information about caring for patients with dementia was available in the staff rest area, where training and information boards were positioned.

Staff in the emergency department had taken steps to support bereaved relatives. A butterfly symbol had been developed to alert staff that a deceased patient and bereaved relatives were present in the department. The opening of the bereavement suite gave relatives a facility to grieve in private.

The emergency department continued to work towards improving services for patients with mental health needs. There was a mental health liaison team employed by a local mental health trust, which was based in the department and worked from 8am to midnight. There was a consultant psychiatrist who worked during the day, Monday to Friday. There were usually three psychiatric liaison nurses on duty who supported the whole hospital. Staff spoke positively about this service which they told us was mostly responsive. Staff told us that out of hours, patients sometimes experienced lengthy delays to be seen by a mental health practitioner. This service was provided by the crisis team, employed by a local mental health trust. There was an on-call psychiatrist who worked at a local hospital, who could be called to attend, but staff told us this did not happen often.

To meet the needs of children and young people with mental health needs the service had recently secured a child and adolescent mental health liaison service. This was available seven days a week 4pm until midnight, which was the time staff had identified the demand for this service was greatest.

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

**Emergency Department Survey 2018**

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

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Overall, how long did your visit to A&amp;E last?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Were you given enough privacy when being examined or treated?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey, published 2019)

**Access and flow**

Patients were not always able to access care and treatment in a timely way and in the right setting.

Managers monitored waiting times and reviewed available data. Although the arrival to treatment time data was positive from July 2018 to April 2019, the trust failed to meet the four hour decision to treat, discharge or admit standard and patients waiting more than four hours from the decision to admit until being admitted also performed worse than the England average.

However, the service had taken some action to improve the time to treatment and patient flow. The major treatment area B had been transformed from an area where patients were treated on a trolley, to an ambulatory major treatment area, where most patients were accommodated on chairs. Additionally, the frailty team was helping to flag elderly frail patients who could be admitted to the frailty unit and then discharged home with the appropriate support.

Staff told us that other efforts to improve access and flow included the emergency nurse practitioners now sitting with the navigator nurses to “see and treat” patients with minor injuries such as sprains and strains. This meant patients could be seen quicker without having to go through the triage process. Staff told us this had reduced patient waiting time by 20 to 30 minutes. However, we did not see this in action during the days of our inspection.

**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 should be no more than one hour. From September 2018 to April 2019 there was an upward trend in the median time to arrival, and at February 2019, the trust exceeded (worse than) the standard and national average.
Median time from arrival to treatment from July 2018 to June 2019 at Portsmouth Hospitals NHS Trust

![Graph showing median time from arrival to treatment from July 2018 to June 2019 at Portsmouth Hospitals NHS Trust](image)

(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 emergency department.

From July 2018 to April 2019 the trust failed to meet the standard and performed worse than the England average. This was similar to our findings at the previous comprehensive inspection in 2018.

Please note that the trust is participating in NHS England & NHS Improvement’s Clinical Review of Standards field test of revised access standards. Reporting against the 4-hour standard is not required by NHS England and Improvement during the field testing, which started in May 2019. Performance against the revised standards is not publicly reported to prevent any mis-interpretation.

(Source: Memorandum of Understanding Relating to the arrangements regarding participation in the Clinical Review of Standards field testing of national urgent and emergency care access standards, NHS ENGLAND & NHS IMPROVEMENT)

This meant it was difficult to assess whether any of the initiatives the service had introduced were making a significant positive effect on patient flow and access to the service.
Four hour target performance - Portsmouth Hospitals NHS Trust

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

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

From August 2018 to July 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently higher than the England average. Our review of the trust’s data showed that for the period 14 to 19 October 2019 (the dates of the core service inspection), showed there had been a total of 205 patients waiting between four and 12 hours from the decision to admit to being admitted. However, the numbers of people waiting more than four hours from the decision to admit to being admitted had reduced from the number of patients that experienced such a delay at the last comprehensive inspection in 2018. This meant there was some improvements in the service provided and the patient experience.
Percentage of patients waiting more than four hours from the decision to admit until being admitted - Portsmouth Hospitals NHS Trust

(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 August 2018 to July 2019, only one patient waited more than 12 hours from the decision to admit until being admitted. This occurred in February 2019. There had been no patients in October 2019 waiting over 12 hours for the decision to admit to being admitted. This was an improvement from our findings at the last comprehensive inspection carried out in 2018.

(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 July 2018 to February 2019 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment could not be provided due to suppression of low numbers. Between March 2019 and June 2019, the monthly percentage of patients who left before being seen was much higher than the England average.
Percentage of patient that left the trust’s urgent and emergency care services without being seen - Portsmouth Hospitals NHS Trust

![Graph showing percentage of patients leaving without being seen](image)

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

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

The trust’s monthly median total time in A&E for all patients was in line with the England average from July 2018 to December 2018. From January 2019 onwards, the trust’s median total time in A&E was higher (worse) than the England average and higher (worse) than patients experienced when we carried out the previous comprehensive inspection in 2018.

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

![Graph showing median total time in A&E](image)

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

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints
Trust level

From June 2018 to May 2019 the trust received 140 complaints in relation to urgent and emergency care at the trust (19% of total complaints received by the trust). The trust took an average of 45.0 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>50</td>
<td>35.7%</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>30</td>
<td>21.4%</td>
</tr>
<tr>
<td>Admissions / transfers / discharge procedure</td>
<td>24</td>
<td>17.1%</td>
</tr>
<tr>
<td>Communication (oral)</td>
<td>14</td>
<td>10.0%</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>4</td>
<td>2.86%</td>
</tr>
<tr>
<td>Access to Treatment</td>
<td>4</td>
<td>2.9%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>4</td>
<td>2.9%</td>
</tr>
<tr>
<td>Competence</td>
<td>3</td>
<td>2.14%</td>
</tr>
<tr>
<td>Patient privacy / dignity</td>
<td>2</td>
<td>1.4%</td>
</tr>
<tr>
<td>Personal records</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Patient status</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Failure to follow agreed procedures</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Aids / appliances / equipment</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Date for appointment-delay/cancellation (outpatient) (APDELO)</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From June 2018 to May 2019 there were 160 compliments about urgent and emergency care at Queen Alexandra Hospital.

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

Patients were encouraged to report concerns about their care and treatment. We found leaflets in the reception area, which directed patients and visitors to the trust’s Patient Advice and Liaison Service (PALS). There were PALS leaflets available, which contained contact details, including a telephone number, and email address. Another leaflet entitled “Why am I waiting?” set out the reasons why delays may occur in the emergency department and described the different pathways into and through the emergency department. It also invited patients to make a comment or suggestion, as described in the ‘Your experience matters to us’ leaflets, available in the department.

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

We reviewed five complaints received by the service. This showed that each concern raised by the patient was investigated and the patient was informed in writing about the findings. Patients also received an apology about their experience, were advised about actions taken by the service to reduce the risk of other patients having similar experiences and where appropriate the complaints response was used as an opportunity to provide health education. Patients were advised how they could contact the trust for further discussion about their concerns and about how to escalate their complaint if they were not happy with the response.

**Is the service well-led?**

**Leadership**

Leaders had the integrity, skills and abilities to run the service. They understood the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Clinical leadership for the emergency department was provided by a care group director, care group manager, senior lead nurse, business manager, governance lead and supported by two matrons. Staff told us that all the local management team were visible and accessible and were frequently seen on the floor, providing help.

The leadership team appeared well informed and had a cohesive view of what needed to be done. However, it was not clear whether the team had the tools to give them an accurate oversight of all aspects of the service to enable them to identify all areas for improvement.

Staff told us the executive management team was also very present and they believed that most of the executive team understood the challenges faces by the department in delivering a safe and effective emergency medicine service.

New divisional structures were introduced in the hospital in June 2018. The emergency department was now part of the medicine and urgent care division. Staff said this had supported improved cross working with the acute medicine unit.

There had been investment in leadership training, medical and nursing staff attended joint leadership training. Staff reported this had improved shared understanding between the medical and nursing staff about the leadership challenges for both professions.

The service was considering the leadership development of all staff, which was supporting succession planning. Band seven nurses were presently receiving leadership training, with the same training planned to be rolled out to band six nurses in 2020.

**Vision and strategy**

The service did not have a developed vision and purpose for the Emergency Department and Urgent Care Group. They were developing, with relevant stakeholders, a vision for what it wanted to achieve and a strategy to turn it into action. They planned to have a vision
and strategy focused on sustainability of services and aligned to local plans within the wider health economy.

The service did not have a developed vision and purpose for the Emergency Department and Urgent Care Group. They informed us they were working with an external consultancy agency to develop clinical and managerial leadership. The consultancy agency was also supporting them in formulating a meaningful vision, purpose and operating principles of the Emergency Department and Urgent Care Group.

The service had included the views of staff to help develop their improvement journey and vision for the department. This included use of a Listening in Action event in December 2018 and a recent staff survey.

The service had considered the views of external stakeholders, including NHS improvement, Healthwatch and patients to support the development of an improvement plan that met the needs and demands of the local health economy.

Areas identified for improvement included the ambulance handover and pitstop processes, emergency department processes, leadership, cultural change, care and compassion, frailty, mental health, minors and urgent care process and recruitment and retention.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

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

Staff recruited from other countries, said they felt welcomed into the service, felt part of the team and that staff supported them in adjusting to working in a different country whilst at the same respecting their cultural differences.

The wellbeing of staff was considered and taken seriously by the leadership team. At the beginning of each shift there was a five-minute team building exercise. We observed one hand over, which included a five-minute quiz. This was clinically based, fun and resulted in a palpable positive team spirit. A debrief session was offered at the end of every shift, so staff could off load any issues or concerns from the shift before going home.

Staff knew how to raise concerns and were confident they would be dealt with appropriately. The trust had a freedom to speak up guardian and most staff knew how to contact them and understood their role.

The department had a culture of recognising staff achievements. Junior medical staff were nominated as trainee of the month and all staff could be nominated for star of the month.
Governance

Leaders operated governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, although staff of all levels were welcome to attend the governance meetings this was not possible due to work load.

There was a lead consultant for governance and the head of nursing led on quality and safety for nursing matters. They were supported by a governance coordinator and governance administrator.

There were monthly meetings of the divisional governance and quality committee. We reviewed the records of governance and quality meetings for July, August and September 2019. We saw that although there was medical presentation from the governance lead who was also the associated clinical director of the department, the care group director did not attend any of these three governance and quality meetings. There were standing items on the agenda each month and, in addition, there was a different focus each month. Staff told us the governance meetings were open to any member of staff who wished to attend. However, workloads meant there was limited opportunity for staff who were not part of the senior governance team to find the time to attend the meetings.

There was managerial oversight of complaints and incidents. The governance coordinator and an administrator maintained a database of complaints and incidents and arranged for these to be reviewed by the management team and monitored the progress of investigations. There were weekly panels to review incidents which were graded ‘moderate harm’ or above. Staff told us that outcomes from the weekly panels, included shared learning across the trust.

The service acted to make sure all staff had an understanding about what was happening in the department. Governance newsletters were produced each month, sent to all staff by email and displayed in the emergency department.

Management of risk, issues and performance

Not all risks were identified and included in the risk management process. There was lack of pace with plans to improve performance of the service. Leaders had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

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

The service maintained a risk register which recorded known risks and rated them according to their potential impact. The highest rated risks related to negative impact and potential for harm to patients cared for in a queue in the department, the risk of delay in treatment, diagnosis and poor experience for patients waiting the reception waiting area and that patient safety could be compromised as there were high numbers of newly recruited nurses who required emergency care skills education and training. We noted that the risks associated with the reception waiting area, did not consider the risk of harm to patients due to undetected deterioration and did not consider the risk of patients not being seen by the navigator nurse in turn of their arrival. We asked the trust for a risk assessment for the environment of the department. The risk assessment they provided detailed risks to staff, but no reference of risks to patients or to the service.
The high-level risks mostly matched those described by staff as on their ‘worry’ list, which they described as care of mental health patients, problems associated with crowding and staffing.

At the previous comprehensive inspection in 2018 we judged there were some omissions from the risk register, which meant there was lack of oversight of risks. Our review of the risk register during this inspection, showed that the risks identified during the previous inspection had been added to the risk register.

Our review of incident reports for October 2019, showed there had been two incidents of self-presenting patients having delayed treatment due to not being booked onto the emergency department’s electronic record system. This was a risk we had identified during our inspection when a patient in the reception waiting area had not been booked onto the electronic record system. There was no reference to the risk of patients not being booked onto the electronic record system on the departments risk register.

Each risk on the register had an identified lead manager, review date and detail of any actions completed or planned to mitigate the risks. This was an improvement from the comprehensive inspection carried out in 2018. The risk register was regularly reviewed at the divisional governance and quality meetings.

The service had plans to cope with unexpected events. The service had grab packs which meant staff had instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents. The trust had emergency generators which provided power for the department in the event of power failure.

The trust’s ‘Full Capacity Policy’, detailed the trust’s four full capacity escalation levels and the associated actions to support improvement in capacity and reduce risk to patients. This included the emergency department opening cohort areas in response to the numbers of patients attending the department and the number of patients being held in ambulances for over 30 minutes. Staff were aware of the four escalation levels, and it was clearly displayed throughout the department what the levels were and what level of escalation the department was in on each shift.

Quality and performance was monitored and reviewed through monthly medicine and urgent care division performance and accountability review meetings. These meetings included review of performance against the emergency care standards, review of friends and family test scores, and action plans for improvement in performance including ambulance handovers.

There was lack of pace with plans to improve performance such as ambulance handover times, with many measures still not meeting the national standards and, in some cases, performing worse than the national average. However, staff we spoke with were aware of most of the areas of performance that needed improvement and told us about their involvement in some of the improvement plans.

**Information management**

The service collected data and analysed it to understand performance, make decisions and improvements. The information systems were integrated and secure. However, the service did not have the information to monitor performance in all areas of the service.

The service collected, analysed, managed and used information to support all its activities. There was real time information available to show departmental activity and operational performance and there was a daily review of metrics and breach analysis by the senior management team.
However, the service did not have the information to monitor performance in all areas of the service. There was a lack of full audit of patient records and lack of monitoring the time self-presenting patients waited for assessment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service used the friends and family test to capture patients’ feedback. They also used the feedback received through patient complaints to support improvements to the service.

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

With a staff questionnaire, leaders had identified the areas staff thought were the problem areas. These included staff wellbeing, staff skill mix, safety, and process flow. Working groups had been set up, that included all grades and roles of staff, to work on how these areas could be improved. There were several working groups established to review different stages of the emergency department patient pathway and quality improvement initiatives.

Staff who had been recruited from overseas, spoke about how staff from the department supported them to adapt to working in a foreign country. This included helping them to understand the culture in England, practicalities of living in England and staff interest in the culture of the country they originated from.

The service engaged with key stakeholders, including the clinical commissioning groups, GP partners, National Health Service Improvement and the local NHS ambulance trust and other external organisations. With the clinical commissioning group and GP partners the service had reviewed the demand of primary care presentations in the department to develop a service to meet the needs of these patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff were proud to tell us about quality improvement initiatives, some of which were larger initiatives run by working groups, other of which were small, and led by an individual member of staff.

One initiative led by an individual nurse, was the introduction of orange and green wristbands for patients. A green wrist band alerted staff that that patient needed time critical medicines, such as medicine to manage Parkinson’s disease. An orange wrist band alerted staff that the patient had communication difficulties such as a hearing impairment, speech problems or had a learning disability. This meant staff had enough information to provide care and support to meet the needs of the patient.

Another member of staff had introduced the use of pegs for prescription charts. Once the medical staff had prescribed a medicine for a patient, they attached a peg to the outside of the patient’s
paper records. This meant nursing staff could easily identify if a change had been made to the patient’s prescription chart and administer the medicine.

A non-clinical member of staff had sourced and with the support of clinical staff trialled female urinals in the department. As a result, the provision and use of female urinals was introduced for all patients with a suspected spinal or cervical injury and were being used on both the emergency department in the orthopaedic services in the trust. The trial had identified that the use of urinals was more comfortable for the patient reduced risk of further damage to the patient and reduced risk of injury to staff whilst positioning the patient on a bed pan.

Larger improvement projects included a pilot for paramedics following a set criteria to refer patients directly to the medical ambulatory care unit. This meant the patient would bypass the emergency department, freeing care space for other patients, and the patient would have an improved experience, with not having to wait to be seen in the emergency department.

The introduction of the ambulatory major treatment area meant more patients could be seen and treated. Staff told us this had resulted in patients spending 20 to 30 minutes less in waiting areas.

The management of asthma in the department was a quality improvement project that included improved discharge planning and flagging patients with asthma to the trust's asthma team.

To improve pain relief for patients who had a suffered a fractured neck of femur, medical staff in collaboration with the orthopaedic team, had started using fascia iliaca blocs to manage pain.

Training about quality improvement methods was being delivered to staff.

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**Medical care (including older people’s care)**

**Facts and data about this service**

The medical care service at Portsmouth Hospitals NHS Trust provides care and treatment for a number of key specialties including cardiology, dermatology, diabetology, endocrinology, gastroenterology, general medicine, hepatology, respiratory medicine and neurology services.

The trust’s main site is Queen Alexandra Hospital, which has 1,200 beds. The trust’s acute medical unit (AMU) provides diagnostic assessment for patients admitted as emergencies. A list of inpatient wards at Queen Alexandra Hospital is as follows: C5, C6, C7, D2, D3, D7, E4, E6/7, E8, F1, F2, F3, F4, G1, G2, G3, G4, G6, G7, G9, Acute medical unit.

(Source: Routine Provider Information Request, sites tab, trust website)

The trust had 61,557 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 27,851 (45.2 %), 1,314 (2.1 %) were elective, and the remaining 32,412 (52.7 %) were day case.

Admissions for the top three medical specialties were:

- General Medicine – 20,374
- Gastroenterology – 15,131
- Rheumatology – 6,409

(Source: Hospital Episode Statistics)
During this inspection, we visited a selection of wards across the division, the acute medical unit (AMU), the ambulatory care unit, cardiac catheterisation laboratories and the endoscopy suite. We spoke with 58 members of staff including service leads, doctors, nursing staff, healthcare assistants, housekeeping staff, and administrative staff and attended medical and nursing handover meetings. We also spoke with 10 patients, reviewed 15 sets of medical records and observed interactions between staff and patients.

Before our inspection, we reviewed performance information from, and about, the trust. During and after the inspection, we reviewed a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments and audit results.

We last completed a comprehensive inspection of medical care services in this hospital in April 2018 and rated the medical care as requires improvement for all five domains. Following the inspection we found the following concerns within medical care services:

- Records of patients care and treatment did not always contain updated risk assessments and appropriate individualised care plans. Up to date records were therefore not always available to all staff that provided care.
- Medicines were not always managed safely or stored securely, and medicine fridges were not consistently monitored to ensure medication was kept at required temperatures.
- There were insufficient numbers of staff with the right qualifications, skills, training and experience to keep people safe and provide the right care and treatment.
- Staff did not fully understand their roles and responsibilities with regards to the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS).
- Staff did not always involve patients and those close to them in decisions about their care and treatment. Some patients and relatives told us there was little communication from staff and they were not kept well informed about what was happening.
- Services were not consistently planned or delivered to meet the needs of the local population.
- There were shortfalls in how the needs and preferences of different patients were met in medical and urgent care. Staff did not fully consider the needs of individual patients living with dementia or who had a learning disability.
- Although the medical service treated concerns and complaints seriously and investigated them, there was lack of process to ensure learning from complaints was communicated and shared across all staff groups.
- During our inspection the trust was in the processes of re-designing both their risk and governance structures. While some new processes were in place these had not been fully embedded. There were systems in place to identify, manage and mitigate risks however risks had not been fully identified and risk registers had not been fully completed within the medical services.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust provided mandatory training in key skills to all staff and had processes to ensure staff completed it. Most nursing staff were compliant with their mandatory training updates. This was not the case for the medical staff who did not meet the trust targets for many of the modules.

The mandatory training was comprehensive and met the needs of patients and staff.

Mandatory training completion rates

The trust provided mandatory training updates for staff in a range of subjects. These were delivered using web based and face to face sessions. Attendance and compliance with trust targets was monitored and reported at monthly trust board meetings.

The trust set a target of 85% for completion of mandatory training.

Queen Alexandra Hospital medicine department

A breakdown of compliance for mandatory training courses from 1 April 2019 to 21 July 2019 for registered nursing staff in the medicine department at Queen Alexandra Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>611</td>
</tr>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>611</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>611</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>609</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>609</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>597</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>541</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>547</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>518</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>527</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>488</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>481</td>
</tr>
</tbody>
</table>

At the Queen Alexandra Hospital medicine department the 85% target was met for 10 of the 12 mandatory training modules for which registered nursing staff were eligible.

A breakdown of compliance for mandatory training courses from 1 April 2019 to 21 July 2019 for medical staff in the medicine department at Queen Alexandra Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>289</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>289</td>
</tr>
</tbody>
</table>
At the Queen Alexandra Hospital medicine department, the 85% target was met for four of the 11 mandatory training modules for which medical staff were eligible. Three of the modules missed compliance by a small margin, with a further two (Infection Prevention level 2 and adult basic life support) missed by almost 10% and almost 15%. Due to small numbers, the completion rate for manual handling (people) should be treated with caution.

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

Staff told us they received email reminders when training was due to be completed and it was discussed with their line managers at their appraisal.

Staff were aware of the requirement to complete mandatory training and managers had a good understanding of their teams’ compliance levels with completion of training. Staff confirmed where they were out of date on a module, a training course had been booked for them to attend. We saw managers held training records and new training dates were identified for staff who missed scheduled sessions.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However not all medical staff completed their training and compliance fell short of the trust target for some modules.

Staff received training in safeguarding adults and children. The trust also delivered Prevent training, which is a national programme to help staff recognise people who were at risk of radicalisation and prevent terrorist activity.

Staff knew how to identify adults and children at risk of, or suffering significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Nursing staff could confidently talk us through the identification of safeguarding concerns and how to report these; they had support from the trust safeguarding leads.

The trust set a target of 85% for completion of safeguarding training.

**Queen Alexandra Hospital medicine department**

A breakdown of compliance for safeguarding training courses from 1 April 2019 to 21 July 2019

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Reporting</td>
<td>281</td>
<td>304</td>
<td>92.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>279</td>
<td>304</td>
<td>91.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>256</td>
<td>304</td>
<td>84.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>254</td>
<td>304</td>
<td>83.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>226</td>
<td>272</td>
<td>83.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>219</td>
<td>291</td>
<td>75.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>196</td>
<td>278</td>
<td>70.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>183</td>
<td>295</td>
<td>62.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>3</td>
<td>8</td>
<td>37.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
for registered nursing staff in the medicine department at Queen Alexandra Hospital is shown below:

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>609</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>518</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>588</td>
</tr>
<tr>
<td>Prevent Basic Awareness</td>
<td>580</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>523</td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>466</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>6</td>
</tr>
</tbody>
</table>

At Queen Alexandra Hospital’s medicine department the 85% target was met for five of the seven safeguarding training modules for which registered nursing staff were eligible.

Two of the eligible nursing staff had not completed level 3 safeguarding children. staff had access to relevant level 3 trained staff to contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there were safeguarding or child protection concerns.

Safeguarding training included Female Genital Mutilation (FGM). Staff explained how they would escalate concerns to either the senior sister in charge, or straight to the safeguarding team for advice. Staff knew how to assess patients at risk of suicide or self-harm and could make referrals to the mental health liaison team if needed. A breakdown of compliance for safeguarding training courses from 1 April 2019 to 21 July 2019 for medical staff in the medicine department at Queen Alexandra Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>236</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>291</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>248</td>
</tr>
<tr>
<td>Prevent Basic Awareness</td>
<td>235</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>177</td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>181</td>
</tr>
</tbody>
</table>

At Queen Alexandra Hospital’s medicine department the 85% target was met for two of the six safeguarding training modules for which medical staff were eligible.

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

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
The trust had an up-to-date infection prevention and control policy, which set out the responsibilities of all staff in relation to the prevention and control of healthcare associated infections.

We saw hand gel available throughout the clinical areas. Monthly hand hygiene audits showed staff were compliant with processes for cleaning their hands between patients and being ‘bare below the elbow’. Patients told us staff decontaminated their hands before providing care and we observed this during our inspection. Each ward received hand hygiene audit results, these were discussed at safety huddles and displayed for staff and the public to see. For example hand hygiene audit results in the acute medical unit for the six months prior to our visit were as follows:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>88.5</td>
<td>94.14</td>
<td>94.00</td>
<td>94.57</td>
<td>90.17</td>
<td></td>
</tr>
</tbody>
</table>

Ward areas were tidy and visibly clean. Sluices and dirty utility rooms were tidy, with linen and waste segregated into colour coded bags. Staff cleaned equipment between use and commodes were visibly clean with ‘I am clean’ stickers attached to indicate they were available for use.

Patients who needed invasive devices for treatment had their risk of infection minimised by staff who followed trust protocols. Staff undertook monthly audits of peripheral venous cannulas (lines in peripheral veins to deliver medicines or fluids), and urinary catheter insertion. Results showing comparisons with previous audits, were displayed on noticeboards in ward corridors and discussed at safety briefings. Matrons discussed these results and actions were identified for improvement, such as additional training for staff and updating protocols.

The medical care division followed trust processes to prevent infection spreading to, or from patients. The infection control team for the hospital developed policies which were in line with national guidance. The trust monitored the number of infections occurring in the medical care division. The annual infection prevention and control report for 2017-18 reported on the activities and monitoring put in place to improve the instances of healthcare acquired infection such as clostridium difficile which was a key priority for the trust in 2018-19.

We observed a member of staff cleaning a walking frame thoroughly before issue to a patient, however we did see several instances of staff using the wash hand basins to dispose of dirty water after washing patients.

The trust reported 10 cases of hospital-onset E.coli bloodstream infection in September 2019, this was below the national average for the year to date. The source of the E.coli infections were varied.

The service reported six cases of hospital-onset MSSA bloodstream infection for the year up to September 2019, resulting in an increased rate of these infections to above the national average with 11.7 cases per 100,000 bed days, compared to 9.8 cases nationally.

The Medicine & Urgent Care Division had reported one incidence of MRSA bacteraemia in the reporting period June 2018 – May 2019, in September 2018. There were also 10 unrelated cases of Clostridium Difficile.
Patients with an infection or who were at risk of contracting an infection were isolated in side rooms wherever possible.

Staff were encouraged to have flu vaccinations to prevent the spread of the infection and during the 2017-18 year 69.2% of trust staff had received the immunisation, which was an improvement on the previous year but did not meet the 70% national requirement.

The most recent Patient Led Assessment of the Care Environment (PLACE) audit results were published in August 2018 and included the cleanliness of the wards. The trust achieved a cleanliness score of 97.9%, the national average score for cleanliness was 98.5%.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. There was appropriate room for patients to be cared for safely, and fire exits were clearly marked with no blocked exits. Ward areas were arranged in bays and could be used for male or female depending on the demand. Patients who needed enhanced care were placed closest to the nurses station.

The trust had a system for ensuring equipment was maintained. All the equipment we checked had been serviced and was within its next service date. Store rooms were available in each ward. We checked consumable items such as syringes, dressing packs, swabs and needles, at random within these storage areas and found all to be within the advised use by dates.

Staff carried out daily safety checks of specialist equipment, we found resuscitation trolleys were consistently checked in full every month, with daily checks completed and signed by staff.

The service had enough suitable equipment to help them to safely care for patients. All equipment observed had been serviced to confirm safety for use. Appropriate equipment was available to staff to help manage risk, for example pressure relieving mattresses and fall prevention equipment.

Some areas were working with aging equipment, for example, some of the equipment in the cardiac catheter laboratories was 12 to 13 years old and at the end of its’ expected lifespan. Equipment failure sometimes led to interruptions in service. This was identified on the risk register and the capital replacement plan.

The endoscopy team told us ‘the decontamination team are excellent and have just won the Hidden Heroes Award.’ The endoscopy decontamination equipment has been in place since 2009 and a business case has been signed off for their replacement. The current machines have a one hour cleaning cycle whereas the new ones will be 30 minutes, which will help to improve efficiency. At the time of our inspection there were some ongoing building works in the unit which meant that there was limited storage so a lot of equipment was lined up in the corridors.*

There was no store room on the stroke rehabilitation unit which meant storage was an unresolved problem with equipment littering the corridors.

Staff followed procedures for managing, storing and disposing of waste safely. We saw staff separated waste appropriately.

* Post inspection note: The building works were completed shortly after our inspection as planned

**Assessing and responding to patient risk**
Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Nursing staff carried out a range of comprehensive risk assessments for patients and identified risks were documented on care plans. These included risks of falling, pressure ulcer risk assessment, mobility, dependency score, risk of developing venous thrombo-embolism (blood clot) and nutritional status. Electronic patient assessments were completed which documented the risks and paper care plans were developed from these assessments. Risks were highlighted as symbols on patient boards at the nursing station which were visible for staff but not clear to visitors of the meaning. Each shift updated the care plan and handed over details of developing risks and condition updates for each patient to the staff taking over. This included actions taken during the outgoing shift and plans for care that needed to continue. Patients told us they felt safe and staff checked on their wellbeing and comfort regularly and call bells were answered promptly most of the time. Patients’ conditions were monitored by staff using a national early warning score (NEWS 2) to determine whether a patient was deteriorating. Staff at Queen Alexandra hospital have been using NEWS 2 since February 2019.

We saw data published in May 2019 which showed that the hospital mortality for coded sepsis had shown a sustained reducing trend since Feb 2018 which was significantly below the national average.

The trust had a deteriorating patient group which began to collect data on deteriorating patients from April 2019. Staff wished to reduce harm related to failure to recognise and provide prompt treatment to the deteriorating patient including those with sepsis.

There had been an improvement in numbers of patients being escalated by the nursing staff, from 38% in December 2017 to between 50-57% in March-May 2019.

There had been a gradual improvement in the numbers of escalation plans being documented from 39% in December 2017 to 75% in May 2019.

There was better documentation of the discussion/review by a Consultant improving from 43% (December 2017) to 72% (May 2019).

The audit report recognised where staff were failing to meet standards relating to timeliness of clinical review and seniority of the clinician performing the review.

Compliance with Sepsis screening and timely antibiotic delivery was also recognised as inadequate; improving the time to delivery of antibiotics through increasing the number of nursing staff with IV competency was underway at the time of our visit to address this and improve results.
Also a junior doctor’s induction competency had been developed for the new intake in August 2019.

As part of their conditions of registration with CQC the trust was required to submit data about the number of overnight bed moves patients experienced during their admission. Data submitted by the trust for the reporting year July 2018 to June 2019 showed that the number of bed moves varied from month to month and between different wards with the highest number of moves made on wards E7 (27 moves May 2019), E8 (27 moves in January and April 2019) and C6 (27 moves May 2019). High numbers of movement in a ward during the night causes disturbance for patients and affects their care. At the time of our inspection overall bed occupancy was 95%, but for medicine and care of the elderly it was 98-99%. The service aim was to get down to a safe 92% to reduce the need for internal transfers.

Medical outliers were between 40 and 50 on a daily basis; on the first day of our visit there were 19 medical and 21 Care of the elderly outliers. The service operated a system of “buddy” outlier wards which mostly worked well and ensured that patients were seen by the appropriate medical teams.

Staff in the endoscopy units followed processes to reduce risk to patients. They used a nationally recognised scoring tool to determine patients’ likelihood of bleeding post procedure. If a patient was identified as high risk of bleeding the procedure was carried out by a consultant endoscopist, rather than a nurse endoscopist. Throughout the procedure, a member of staff monitored the wellbeing of the patients, monitoring the patient’s vital signs to identify and act on any signs of deterioration. Staff followed the World Health Organisation (WHO) safety check list “Five Steps to Safer Surgery” to reduce risk to patients.

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

The Gastroenterology and Hepatolgy medical teams operated with a consultant of the month, which reduced the risk of mistakes due to lack of continuity of care.

The trust continued to initiate the ‘SWARM’ process introduced prior to our last inspection to support learning from and prevention of further patient falls. The ‘SWARM’ process was started by the NHS Improvement collaborative and was continued by the trust. A team that included a matron, nurse in charge of the ward, a practice educator, lead falls nurse, pharmacist (if required) supported the ward to review patient falls. The review process included checks that staff followed the falls policy, staff completed a post falls check list, the patient had a medical and medication review, staff identified risk factors and staff identified actions and followed them through.

Data submitted by the trust showed that compliance was good in some indicators but very poor in others and the improvements were not consistent.
The information provided includes trust wide numbers, although the medical and urgent care wards will form a large percentage of the submission. There was an ongoing improvement project in operation on the acute medical unit, musculoskeletal services, the renal and some medicine for older peoples wards. This took the form of a template to identify and document learning from each falls incident.

Ward D2 was a short stay ward which was usually used for patients who were assessed in line with agreed criteria as unlikely to need consultant geriatrician input. Most of the patients on the ward were transferred from the acute medical unit. The staff made this ward safer by cohorting patients in bays, for example, those likely to fall. An extra support worker would be assigned to a bay for groups of confused patients.

**Nurse staffing**

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers had completed a ward based staffing review since our previous inspection in 2018, following which the trust produced a report which detailed the vacancy rate at ward level and outlined recruitment plans and the formal introduction of two band 4 roles, the ‘Nursing Associate’ and the ‘Assistant Practitioner (Nursing)’.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. There was not always enough nursing and therapy staff to provide optimum patient care. However, patient safety was a priority for all staff we spoke with. Risk to patient safety due to vacancies in nursing workforce was on the divisional risk register, and a recruitment action plan and targeted recruitment processes had been put in place for each care group.

Recruitment of registered nurses from Europe had reduced in 2019 but support with positive recruitment at band 4 continued and successful recruitment from India and the Philippines was expected to fill vacancies by the end of 2019.

We observed some of the daily reviews of staffing across the care groups to support redeployment decisions. Ward managers were included in the reviews and all the nursing staff we spoke with were appreciative of the efforts made to deploy staffing effectively, and they were very supportive of each other’s ward capacity and turnaround.
The senior sister on the short stay unit told us they were fully staffed but the skill mix wasn’t quite right, as there were six new starters recently, so they expected the team skill mix to be improved by January 2020. There was a similar picture on the ward F4 stroke unit, where there had been a high level of bank and agency use, until recent recruitment had reduced this. There were five specialist stroke nurses on duty 7 days weekly from 7.30am to 8.30pm, they were three short for a full duty rota.

The cardiology ward manager told us there was one nursing vacancy on the ward. They had a higher establishment than general wards due to the need for enough staff to be able to constantly watch monitors for patients in individual cubicles.

The staffing compliment for the renal medicine wards (G6 and G7) was sufficient at the time of our inspection. However, ward managers told us that they often found that this meant they would need to lose a registered nurse to support areas of the division with higher acuity of patients. This was managed by reallocating a healthcare assistant to support the renal medicine team.

Almost all staff we spoke with said they were always able to manage safely but felt they could improve care by spending more time with the patients if they did not have to redeploy staff to other areas.

We asked the trust for some examples of nursing rotas from randomly selected weeks to see how frequently planned versus actual staffing numbers were breached, but these were not received.

The table below shows a summary of the nursing staffing metrics in medicine at Queen Alexandra Hospital compared with the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>2,102.8</td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td>74,733 (24%)</td>
<td>151,141 (49%)</td>
<td>84,581 (27%)</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>734.0</td>
<td>21%</td>
<td>14%</td>
<td>4.9%</td>
<td>74,733 (24%)</td>
<td>151,141 (49%)</td>
<td>84,581 (27%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within medicine at Queen Alexandra Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank use or agency use.

The table below shows a summary of the updated nursing staffing metrics in medicine at Queen Alexandra Hospital compared to the trust’s targets, where applicable:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>2,103.1</td>
<td>10%</td>
<td>13%</td>
<td>4.1%</td>
<td>89,043 (29%)</td>
<td>143,016 (47%)</td>
<td>74,539 (24%)</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>715.4</td>
<td>19%</td>
<td>14%</td>
<td>4.7%</td>
<td>89,043 (29%)</td>
<td>143,016 (47%)</td>
<td>74,539 (24%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

* Please note that sickness data was provided for the time period October 2018 to September 2019

Vacancy rates

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

Monthly vacancy rates over the last 12 months for registered nurses, showed a shift from December 2018 to May 2019. Recruitment plans were continuing to take effect throughout the year; at the time of the inspection there had been successful recruitment both locally and overseas. All new staff were supernumerary for a period of time which was a pressure for all ward staff who continued to work with reduced numbers until induction for the new staff was complete. The trust told us that they backfilled staff whilst they completed their supernumerary period.

Sickness rates
Monthly sickness rates over the last 12 months for registered nurses, shows a shift from December 2018 to May 2019.  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Medical staffing**

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

The table below shows a summary of the medical staffing metrics in medicine at Queen Alexandra Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td>2,102.8</td>
<td>10%</td>
<td>13%</td>
<td>4.1%</td>
<td>22,517 (17%)</td>
<td>42,135 (31%)</td>
<td>71,322 (52%)</td>
</tr>
<tr>
<td><strong>Medical staff</strong></td>
<td>322.6</td>
<td>10%</td>
<td>7%</td>
<td>1.0%</td>
<td>22,517 (17%)</td>
<td>42,135 (31%)</td>
<td>71,322 (52%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The table below shows a summary of the updated medical staffing metrics in medicine at Queen Alexandra Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td>2,103.1</td>
<td>10%</td>
<td>13%</td>
<td>4.1%</td>
<td>39,475 (38%)</td>
<td>40,348 (39%)</td>
<td>23,280 (23%)</td>
</tr>
<tr>
<td><strong>Medical staff</strong></td>
<td>325.9</td>
<td>8%</td>
<td>7%</td>
<td>1.5%</td>
<td>39,475 (38%)</td>
<td>40,348 (39%)</td>
<td>23,280 (23%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

* Please note that sickness data was provided for the time period October 2018 to September 2019

The following is the graph for bank and agency hours:
Medical staffing rates within medicine at Queen Alexandra Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover. Data shows that vacancy rates had reduced significantly during the reporting year June 2018 to May 2019, and the service had a good mix of consultant and junior doctors within teams.

The short stay unit reported sufficient medical staff; the medical team consisted of one consultant of the week for seven days (08.00-17.00), two registrars, plus three to four other junior doctors.

The stroke service had two substantive consultants working full time with two substantive consultants working part time, these were supported by three full time locum staff. This was sufficient to run the service but the view of senior medical staff was that this did not allow the service to advance as much as they would like. The consultant team was supported by eight junior doctors at various stages of their training.
Vacancy rates

Monthly vacancy rates over the last 12 months for medical staff were unstable and may be subject to ongoing change.  
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates

Monthly sickness rates over the last 12 months for medical staff were unstable and may be subject to ongoing change  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
Monthly bank hours over the last 12 months for medical staff were unstable and may be subject to ongoing change.

![Agency hours - medical staff](image)

Monthly agency hours over the last 12 months for medical staff shows a shift from December 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

### Staffing skill mix

In April 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

### Staffing skill mix for the 282 whole time equivalent staff working in medicine at Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>24%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>22%</td>
<td>20%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (SpR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/04/2019 - 30/04/2019)

### Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
At the last inspection in 2018 we found that staff had improved their management of patient records following a warning notice issued in 2017 requiring the trust to make significant improvements with regard to ensuring staff held patient records securely and that patient records were fully completed. However, we still found gaps in most records, assessments were not completed and information in some records was conflicting. 

During this inspection we reviewed 15 sets of patient records and found records were generally of good quality, detailed and usually completed well. However there were exceptions where, for example fluid balance did not have totals for input and output documented and patients on treatment pathways for pressure ulcers did not have daily skin checks documented.

We found that the trolleys containing patient records were kept locked in all the areas we visited, except when they were in use by the staff, at which time we saw that staff did not leave the trolleys unattended.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

The trust held an annual medication safety drop-in day, which was attended by more than 270 hospital staff; there were a number of stands showcasing different medication safety topics such as oxygen prescribing, insulin prescribing, use of syringe drivers and checking medicines for going home.

The trust had an off-site licensed aseptic manufacturing unit located two miles away from the hospital. This unit met the requirements of patients and was responsive to last-minute requests, often critical for oncology patients when chemotherapy was scheduled pending blood results.

The trust had introduced the “Does another ward stock what I want?” system which was accessed easily from the pharmacy page on the hospital intranet. It meant staff could enter the name of a medicine and the system displayed all of the wards where the medicine was held as stock to allow ease of access to medicines.

We reviewed drugs charts in AMU, these were clearly written and medicines were marked as administered as prescribed. On the cardiology ward we observed staff completing the medicines round which took almost two hours. This meant some patients did not receive their 8am medicine until 10am. This could easily be rectified had the band 5 nurse been supported by a more senior colleague.

We saw some inconsistency around checking of patient identification before administering medicines; staff did not always check allergy status with the patients.

We saw that controlled drugs (CD) cupboards and records, medicines cupboards, and fridge temperature records on wards and departments we visited were checked and complied with regulations. However we found that the inner locked CD cupboards, particularly those in the G level wards were untidy as CD stock was mixed with expired stock and patients’ own medicines. Staff were unclear about the expiry time for some stored medicines after opening as labels did not always clarify this.

We noted there were old style resuscitation trolleys used in various locations. These trolleys had unlocked drawers containing consumables, sodium chloride ampoules and fluids which had been risk assessed in accordance with the trust policy. The gold standard was to have tamper evident
trolleys throughout. New trolleys were in use in some areas, for example in the acute medical unit (AMU) and some C level wards. The large new resus trolley in AMU had an open space at the bottom to house two portable black and blue sealed drug carriers which were for easy staff access, but we saw that these bags were also accessible to the public. The location of the trolley was in a recess along the corridor, because there was shared use by three areas with busy public footfall. We suggested that the trolley could be turned sideways to hide the carriers from public view. The staff in this area stored the sharps bin attached to a stand on the trolley, we noted this could be unsafe as it could easily fall off when the trolley was accessed in an emergency due to the speed of movement.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with were familiar with the reporting system and described incidents they would report. This included but were not limited to, pressure ulcers, patient falls and infection control incidents. Incidents were reported externally to the National Reporting and Learning system in line with NHS Improvement’s serious incident framework (2015). Incidents were allocated to senior staff for investigation. Staff told us they did not always receive individual feedback but themes were highlighted at safety briefings and displayed in staff areas. Ward managers told us they fed back to staff individually if this was indicated in the investigation. We reviewed four serious incidents and found the investigations had been thorough with actions identified to prevent reoccurrence. Actions were allocated to a responsible staff member however one record had no date of when actions should be completed. This meant there was a risk that actions would not be completed in a timely manner.

Mortality case note reviews were completed for any incident related to deaths. Senior staff told us incidents involving mortality were investigated and any learning shared with all staff. We were given an example of one incident which involved more than one speciality.

Staff received feedback from investigation of incidents, both internal and external to the service. This was shared through safety huddles, team meetings, newsletters and briefings.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

We discussed some serious incidents where patients had fallen causing serious injury to themselves on one of the F level wards. The nurse in charge explained that there were staff available who were trained to carry out thorough investigations. Recommendations were shared with staff and any practice changes made where possible.

Some of the G level and F level wards were particularly challenging with regular violence and aggression from patients. Staff were encouraged to report all instances and complete the ‘Say Way’ forms. As part of the respect and protect campaign SWARMs included representative support from the mental health teams.
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 August 2018 to July 2019, the trust reported one never event for medicine.

The event occurred in October 2018 and related to a misplaced nasogastric tube (NG) tube through which a parenteral feed was administered directly to the lung.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 44 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2018 to July 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>17</td>
<td>38.6%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>13</td>
<td>29.5%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>4</td>
<td>9.09%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>3</td>
<td>6.8%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>3</td>
<td>6.8%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>2</td>
<td>4.5%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>2.3%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>2.27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Duty of candour was applied when appropriate to do so. 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 aware of being open and honest and senior staff were aware of the application of duty of candour. We saw evidence of duty of candour being applied on three occasions. Relatives were contacted and offered an apology as soon as was practicable after the errors had been identified. They were also kept informed of investigation outcomes.
Mortality and morbidity reviews were discussed by each specialty at monthly meetings. Minutes of these meetings showed detailed analysis of patient deaths and treatment of high risk conditions. Staff who were not involved in the case reviewed the records using a structured approach. This was to give an objective professional opinion on how treatment could have been improved. Learning points were shared at these meetings.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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 47 new pressure ulcers, 38 falls with harm and 34 new urinary tract infections in patients with a catheter from May 2018 to May 2019 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Portsmouth Hospitals NHS Trust**

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only
Insert commentary on any trends.

(Source: NHS Digital - Safety Thermometer)

We saw wards displayed information about their safety performance, so this information was clearly displayed for patients, visitors and staff. The safety thermometer was discontinued in April, and therefore the local audit programmes were used to monitor patient harm.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies and guidelines to plan and deliver high quality care according to best practice and national guidance. Staff were able to access policies and guidelines from the trust intranet, we found that the search function worked well, however out of date documents were not removed.

The Microguide for Portsmouth Hospital, widely used for advice on antimicrobial prescribing, was launched in November 2015. The trust aimed to review these guidelines every two years; however, some had one year review dates. This guide was also available as an app on smart phones, which was popular with junior doctors who were able to find guidelines quickly and safely which minimises delays to starting treatment.

Standards relevant to each specialty were being followed. There were programmes of clinical audit to review compliance with standards and identify areas for improvement.

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice 2015. At handover meetings, as well as the physical care, staff referred to the psychological and emotional needs of patients, their relatives and carers. This was also referred to at board rounds where appropriate.

Medical services had pathways and protocols for a range of conditions, which took account of national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. For example, for heart failure, stroke, diabetes, respiratory conditions, falls prevention, pressure ulcer prevention and sepsis.

Doctors provided consistency in care for their patients and reviewed patient conditions regularly. In line with national guidelines, patient records on the Acute Medical Unit (AMU) showed they were seen and reviewed by a consultant twice daily. Once transferred to general ward, records showed, in line with national guidelines, most patients were reviewed during a consultant led ward round once every 24 hours.

The medical care division contributed to national audits and used the information to identify and act on areas for improvement. The hospital’s stroke service worked towards meeting the Sentinel Stroke National Audit Programme (SSNAP) standards.

The leadership team had identified that they needed increased medical support and were exploring options to share posts with another local NHS provider. They had developed a new role to manage the hospital team along with the community service as well as investing in increased
speech and language therapy. In the meantime there was lots of input to upgrade some nurse skills to undertake swallowing assessments.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

We found at our previous inspection care assessments did not fully consider patients’ nutritional and hydration needs. On this occasion we found staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. They worked with dieticians who were based at the hospital to ensure patients nutritional and hydration needs were met.

Staff completed patients’ fluid and nutrition charts where needed although fluid charts were not always completed in full, which meant a detailed record of patient fluid intake and output was not available. Patients told us they were regularly asked if they wanted a drink.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. In records we saw these were completed and scores were given for a patient’s risk of malnutrition. We saw staff giving patients wet wipes to clean their hands before eating and supporting them into a chair to be more comfortable. We saw the staff encouraging patients to eat in all the areas we visited during meal times.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used the Wessex Pain Scale to assess pain levels experienced by patients, this was recorded on the trust electronic patient monitoring system. If a patient was unable to communicate verbally, for example a stroke patient or someone with advanced dementia, staff used the Abbey pain scale. Patients received pain relief soon after requesting it, and told us their pain was well controlled. Staff prescribed, administered and recorded all pain relief accurately. We saw evidence of this when reviewing prescription records. Staff had access to a pain management team to support patients admitted to hospital requiring pain review and pain management if required.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The service performed comparably in national clinical outcome audits. Where performance was below national averages or expected outcomes managers used the results to improve services further.
The endoscopy service was previously JAG (Joint Advisory Group) accredited; this was withdrawn in 2018 due to the lack of space in the recovery area for single sex bays. The trust was addressing this at the time of our inspection, building works were expected to be completed in November 2019. The trust informed us after the inspection that the work was completed as planned.

Relative risk of readmission

Queen Alexandra Hospital

From February 2018 to January 2019, when compared with the England average, patients at Queen Alexandra Hospital had a lower than expected risk of readmission for both elective and non-elective admissions.

Elective Admissions

- Patients in Gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in Clinical haematology had a similar risk of readmission for elective admissions
- Patients in Nephrology had a higher than expected risk of readmission for elective admissions

Elective Admissions - Queen Alexandra Hospital

Non-Elective Admissions

- Patients in General medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in Medical oncology had a higher than expected risk of readmission for non-elective admissions
- Patients in Nephrology had a lower than expected risk of readmission for non-elective admissions

Non-Elective Admissions - Queen Alexandra Hospital

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

Queen Alexandra Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in latest audit, January 2019 to March 2019. We discussed the outcomes with staff who were confident that the thrombolysis service worked well. Insufficient speech and language therapists meant that assessments were completed within the 72 hour target for only 50% of patients. This was less favourable than the previous results.

As a result of cohesive working between the inpatient stroke wards and the community stroke rehabilitation team, 60% of patients at Queen Alexandra Hospital had an early supported discharge. The effectiveness of the community stroke rehabilitation team had significantly contributed to the trust's constant A rating for discharge processes.

### Queen Alexandra Hospital Team-centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C</td>
<td>B</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>D↓</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>A</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

**Team-centred total key indicator level**

<table>
<thead>
<tr>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>B</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

### Overall Scores

<table>
<thead>
<tr>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>B</td>
<td>B</td>
<td>C</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London, SSNAP audit)

**Lung Cancer Audit**

The table below summarises Portsmouth Hospitals NHS Trusts performance in the 2018 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of)</td>
<td>71.2%</td>
<td>Does not meet the audit aspirational standard</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
The National Lung Cancer Audit (NLCA) on the quality of lung cancer care for patients diagnosed between 1st January and 31st December 2016 was published in January 2018. The audit highlighted a few areas requiring improvement in terms of surgical and chemotherapy treated cases, and identified the Trust as an outlier for three areas. The trust submitted a detailed action plan to the National Lung Cancer Audit.

Local monitoring of improvements in NLCA Data Results for Patients Diagnosed in the first half of 2017 revealed:

- Performance Status (PS) recording has improved from 75.1% to 80.2% (audit standard 90%)
- The number of patients seen by a lung Clinical Nurse Specialist has improved from the previous 54.1% (audit standard is 90%)
- A slight improvement in patients receiving anti-cancer treatment from 55.5% to 56.9%; area requires further improvement (audit standard is 60%)
- Non-small cell lung cancer treatment with chemotherapy improved from 55.9% to 60% (audit standard is 65%)

### Case-mix adjusted survival rate

**Case-mix adjusted one-year survival rate**

(Adjusted scores take into account the differences in the case-mix of patients treated)

<table>
<thead>
<tr>
<th>Score</th>
<th>Status</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>32.6%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery

(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)

<table>
<thead>
<tr>
<th>Score</th>
<th>Status</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.8%</td>
<td>Negative outlier</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>

### Case-mix adjusted percentage of patients with advanced NSCLC receiving systemic anti-cancer treatment

(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)

<table>
<thead>
<tr>
<th>Score</th>
<th>Status</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>56.7%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>

### Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy

(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)

<table>
<thead>
<tr>
<th>Score</th>
<th>Status</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>76.1%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: National Lung Cancer Audit)
• Small cell lung cancer treatment has improved from 65% to 76.6% (audit standard is 70%)
• Surgical resection rates have improved from 10.5% to 14.1% audit standard is 17%)
• Curative treatment rates have improved from 61.3% to 75% (audit standard is 80%)
• Survival rates have improved from 32.7% to 42.1% (audit standard is 42%)

**National Audit of Inpatient Falls**

**Queen Alexandra Hospital**

The table below summarises Queen Alexandra Hospital’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>N/A</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>87.5%</td>
<td>Green</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) (Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</td>
<td>41.2%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients assessed for the presence or absence of delirium (if applicable) (Having an assessment for delirium is indicative of good practice in falls prevention)</td>
<td>80.9%</td>
<td>Green</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients with a call bell in reach (if applicable) (Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</td>
<td>84.6%</td>
<td>Green</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>

(Source: National Audit of Inpatient Falls)

The 2017 report identifies 7 key Measures for inpatient falls prevention these are:

• Assessment for the presence or absence of delirium
• Continence or toileting care plan
• Measurement of lying and standing BP
• An assessment for medications that increase falls risk
• Any assessment of vision
• Call bell in sight and reach of patient
• Appropriate mobility aid in reach

Actions the trust have taken to improve outcomes include

• Development of the post falls SWARM template (the SWARM is an immediate review of falls prevention actions following all falls). The acute medical unit, musculoskeletal service, the renal service and some medicine for older people’s wards were using this template to review, identify and share learning and good practice and implement immediate actions to reduce the risk of a fall at the time of our inspection.

• An updated nursing falls assessment and falls multifactorial care plan.

Falls audit data for 2019 provided by the trust showed significant improvements in some of the measures. (Trust-wide)

Key Performance Indicators:

<table>
<thead>
<tr>
<th>Standard - Trust-wide Falls</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-wide Falls Audit (All patients admitted)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying and standing BP completed</td>
<td>85%</td>
<td>20.8%</td>
<td>22.4%</td>
<td>20.0%</td>
<td>31.5%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Medical review for falls documented in the patient’s notes</td>
<td>85%</td>
<td>58.3%</td>
<td>51.4%</td>
<td>53.6%</td>
<td>54.1%</td>
<td>54.3%</td>
</tr>
<tr>
<td>Bed rail assessment completed</td>
<td>85%</td>
<td>93.3%</td>
<td>96.4%</td>
<td>98.2%</td>
<td>97.0%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Falls risk assessment completed</td>
<td>85%</td>
<td>88.3%</td>
<td>95.5%</td>
<td>96.4%</td>
<td>94.0%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Assessment correct</td>
<td>85%</td>
<td>98.1%</td>
<td>94.3%</td>
<td>98.1%</td>
<td>96.0%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Falls risk assessment completed within 6 hours of admission</td>
<td>85%</td>
<td>83.0%</td>
<td>84.9%</td>
<td>92.5%</td>
<td>91.2%</td>
<td>90.2%</td>
</tr>
</tbody>
</table>

Chronic Obstructive Pulmonary Disease Audit

Queen Alexandra Hospital
The table below summarises Queen Alexandra Hospital’s performance in the October 2018 – April 2019 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24hrs of admission? (Specialist input improves processes and outcomes for COPD patients)</td>
<td>72.3%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) (Inappropriate administration of oxygen is associated with an increased risk of respiratory)</td>
<td>100.0%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
</tbody>
</table>
Since September 2017 Queen Alexandra Hospital has had a designated COPD specialist team of nurses and physiotherapists who aim to review patients admitted with an exacerbation of COPD within 24 hours of admission to ensure they are receiving optimal treatment. All current smokers (including those who have smoked in the last 6 weeks, or who use an e-cigarette/vape) received very brief advice on smoking and were offered nicotine replacement therapy (NRT) for use during
their stay in hospital. 89% (median) of COPD patients that were smokers at Queen Alexandra Hospital were prescribed smoking cessation pharmacotherapy.

### National Audit of Dementia

The table below summarises Queen Alexandra Hospital’s performance in the 2017 National Audit of Dementia.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</td>
<td>46.7%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/service able to respond to the needs of people with dementia as they arise?” (This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</td>
<td>74.3%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium (Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</td>
<td>41.9%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Multi-disciplinary team involvement in discussion of discharge (Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</td>
<td>23.5%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Audit of Dementia)

The trust participated in the National Audit of Dementia (NAD), submitting data collected between April and October 2018. The audit reviewed the quality of care received by people with dementia in general hospitals. The audit specifically addressed aspects of care delivery which were known to impact upon patients with dementia while in hospital.
The hospital participated in three parts of the survey:

1. A hospital level organisational checklist
2. A retrospective case note audit with a minimum target of 50 sets of patient notes
3. A staff questionnaire on providing care and support to people with dementia

The three parts included five domains, the scores can be seen in the table below

<table>
<thead>
<tr>
<th>Domain</th>
<th>Percentage</th>
<th>Trust ranking</th>
<th>Comparison to NAD Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>100%</td>
<td>1/195</td>
<td>↑</td>
</tr>
<tr>
<td>Nutrition</td>
<td>67.5%</td>
<td>172/199</td>
<td>↓</td>
</tr>
<tr>
<td>Discharge</td>
<td>83%</td>
<td>67/191</td>
<td>↑</td>
</tr>
<tr>
<td>Assessment</td>
<td>75.4%</td>
<td>171/191</td>
<td>↓</td>
</tr>
<tr>
<td>Staff rating communication</td>
<td>62.4%</td>
<td>138/182</td>
<td>↑</td>
</tr>
</tbody>
</table>

The trust identified the following areas for improvement:

Nutrition:
· Improving carers visiting at mealtimes
· Protected mealtimes keep free of clinical activity
· Access to finger food and snacks
· Ensuring that handover includes communicating nutritional needs

Assessment:
· Improved documentation of weight and any pain
· Assessment of delirium using a recognised tool

Communication:
· Identification of factors that may cause anxiety, and support,
· How a person with dementia understands/communicates effectively
· Use of This is me (or similar)
· Staff having the information to communicate effectively with patients

The senior lead nurse for dementia and end of life care reviewed the results and made recommendations for improvement actions presented to the dementia committee in September 2019 as follows:

Patients with a dementia admitted as an emergency are assessed for Delirium using a standardised tool, where pain is also considered as a contributory factor.

Initial assessments should include:

Information about factors that can cause distress or agitation
Steps that can be taken to prevent these.
Nutrition
Nutrition and hydration needs of patients with dementia are included in nurse shift handovers
Finger food or snacks are available for patients with a dementia

Discharge
Ensuring that patients with a dementia are included in discussions regarding discharge and this is documented in patient notes. The discharge summary should include any occurrence of delirium and behavioural symptoms of dementia along with recommendations for ongoing assessment or referral.

Inpatient moves
Ensure that the Operational team minimise the number of ward moves for patients with dementia and only moving when there is a clinical need.
Trust board to receive information and a report in relation to inpatient moves.

Consider Annual report to Trust board to provide assurance of dementia standards and quality of care and implementation of recommendations from National Audit and Dementia Action Alliance Dementia Friendly Hospital Charter.

The dementia committee had a work plan which was reviewed and updated monthly and some improvements were being explored as part of a quality improvement project.

**Competent staff**

The service met with staff on a regular basis to ensure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development. However the data provided did not reflect this.

**Appraisal rates**

Data provided by the trust showed that appraisal rates were increasing throughout the year, the 85% target was difficult to meet as there was a commitment to recruitment which meant that there was always a percentage of staff who were not ready for a formal appraisal.

From June 2018 to May 2019, 78.6% of staff within the medicine department at the trust received an appraisal compared to a trust target of 85%. Medical and dental staff exceeded the trusts 85% target, however appraisals for nursing staff did not meet the target.

**Queen Alexandra Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2018 to May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>290</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>167</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>447</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>448</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>157</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>48</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>21</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Competencies relevant to the ward specialty and staff role were completed on induction and an ongoing basis. We saw examples of these on wards we visited.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke to staff who had started their role in the last year; they told us they had a full induction to be prepared for the role.

The matrons for older peoples’ medicine explained they had a team of practice educators to support competency training for staff and ensuring new starters were booked onto all induction training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers could also identify any training needs, or specialist training, their staff required to provide opportunities to develop their skills and knowledge. Staff spoke positively to us about the appraisal process.

Both nursing staff and medical staff were supported to develop through regular, constructive clinical supervision of their work. Junior medical staff said they were well supported by the consultants, and arrangements were made for supervision, with protected teaching time and good quality training.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff, teams and services in the medical care and older people division worked well with other areas including those within the hospital and external to the organisation. All areas we visited had comprehensive board rounds. These were multi-disciplinary meetings which included doctors, consultants, nursing staff, social workers and allied health professionals such as physiotherapists and occupational therapists. Patients’ needs were discussed in detail with each discipline contributing to the meeting and plans for further treatment or discharge were decided upon.

All relevant staff were involved in assessing, planning and delivering care and treatment. We observed board rounds, which were attended by medical staff, nurses, allied health professionals and discharge coordinators. These were often led by allied health professionals and contributed to by other team members. During these meetings, it was clear staff worked collaboratively to ensure continuity of care to patients. Staff discussed patients’ treatment and discharge plans and we saw staff were comfortable to challenge whether plans were the most appropriate. Referrals to allied healthcare professionals, frailty team, learning disability team and specialist nurses were also discussed.

Allied health professionals were allocated to specialist wards and were able to provide support within their specialty for other wards. The acute stroke unit had clinical specialist nurses who were able to support staff in the emergency department when a new stroke patient was expected.

All necessary teams, services and organisations were informed when patients were discharged from hospital. Patients were given information about their health in the form of a discharge summary when they left the hospital. This supported them if they had a medical emergency after leaving hospital. A discharge summary was sent to patients’ GPs to ensure they were aware of patients’ health conditions.
All teams were clear about who had overall responsibility for patient care. A medical consultant was allocated to review all outlying patients on other wards and have them moved to their specialty ward when a bed was available or the patient’s condition became more of a priority.

The trust discharge planning team was started in 2016 and was based within the integrated discharge service (IDS). The team were normally involved in the discharge of patients with complex needs and provided expert advice to ward staff and department managers. The team collaborated with other local NHS providers and the local authority. The team identified that in Portsmouth the highest demand came from the people aged over 75 years, and there was an ongoing project to support these people outside of acute care. This was supported by three frailty consultants, a nurse and two physiotherapists with a focus on avoiding hospital admissions for some of this vulnerable age group.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards. Patients were reviewed by consultants depending on the care pathway.

Staff could obtain/access support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Therapy services were provided on week days, with arrangements for weekend cover or on call services where required.

To support quality improvement and measure progress in the achievement of seven day hospital services, all acute Trusts were asked to participate in self assessment surveys since the spring of 2016. These surveys covered the management of patients admitted as an emergency during a specified seven-day period, measured against four priority clinical standards.

A national self-assessment tool had been developed to allow organisations to conduct baseline assessments of the provision of seven day services. The tool enabled Trusts to self-assess current levels of service provision using nationally agreed definitions, and to help understand local needs and requirements to deliver extended services.

The trust has participated in all six national surveys and results showed improvement in performance which led to full compliance for all four priority clinical standards in the spring 2018 survey.

- Standard 2: consultant review within 14 hours of decision to admit
- Standard 5: access to diagnostics
- Standard 6: consultant directed interventions available locally or within a defined care pathway
- Standard 8: once or twice daily review where required

Benchmarking showed the trust was above the national average for clinical standards 2 and 8. The results also confirm that Trust compliance at weekends was very similar to that for weekdays.

In the AMU, there was a consultant on site 14 hours a day, which met the Royal College of Physicians guidelines. Outside these hours, there was a medical consultant on call who could reach the hospital within 30 minutes.
The Community Stroke Rehabilitation Team (CSRT), were part of the Older Persons Medicine (OPM) Care Group, which sat within the Medicine and Urgent Care Division, provided a seven-day service to the trust’s stroke patients in the community.

There was access to pharmacy provision across the service seven days a week.

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

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

Written health promotion information was available for patients. Patients admitted with cardiac health conditions received written information about health promotion in a booklet. We saw health promotion leaflets about alcohol consumption available to patients and their relatives. Specialist nurses worked with patients to identify measures to help them with their health conditions.

On F level wards we saw leaflets about fatigue management, bone health, and top tips to keep active.

Wards displayed information in poster format on specific conditions. This helped relatives to understand conditions and where to access support. This included information about support groups, locally and nationally, and how to access them.

Patients who attended ambulatory care received advice on caring for their conditions at home and when they should seek further help. Patients were able to recognise when they needed to refer themselves for further treatment.

Staff allowed carers to be involved in caring for their relatives as much as they wanted to. When a patient’s care needs changed, we heard how staff had discussed this with carers and provided the additional support where it was needed.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.**

**Mental Capacity Act and Deprivation of Liberty training completion Trust level**

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

**Queen Alexandra Hospital**
A breakdown of compliance for MCA/DOLS training courses from 1 April 2019 to 21 July 2019 at Queen Alexandra Hospital for registered nursing and medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1 Nursing</td>
<td>610</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2 Nursing</td>
<td>541</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1 Medical</td>
<td>270</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2 Medical</td>
<td>208</td>
</tr>
</tbody>
</table>

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

In medicine the target was met for one of the two MCA/DoLS training modules for which medical staff were eligible.

These results were an improvement on the previous year for each element.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They made sure patients consented to treatment based on all the information available, and clearly recorded consent in the patients’ records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff implemented DoLS in line with approved documentation. This was an improvement on the previous inspection when we found that staff in the service did not fully understand their roles and responsibilities with regards to the MCA 2005 and associated (DoLS). People’s mental capacity and DoLS were not consistently assessed and recorded in line with legal requirements.

Mental capacity assessments were undertaken by specialist registrars or consultants in most areas across the division. The trust policy was that for DoLS applications, medical staff had to carry out the assessment to determine whether the patient had capacity to make the specific decision or not. During board rounds, medical staff discussed which patients may or may not have capacity to make decisions and identified those patients that probably had reduced capacity and needed an application of a DoLS authorisation.

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During previous inspections we had found a culture of poor care in some of the areas visited and a warning notice was issued in May 2017 requiring the service to make improvements. The service took action to improve the culture and during the 2018 inspection improvements were noted in most areas and poor care was found in isolated areas only.

During this inspection we found a caring compassionate atmosphere throughout, including areas that were busy and staff were stretched. Patients we spoke with were happy with the care and supportive of the staff caring for them.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we observed positive interactions between staff and patients, providing kindness in care.

Staff followed policy to keep patient care and treatment confidential. Staff spoke quietly or within private areas when discussing patient care and treatment.

Patients said staff treated them well and with kindness. However, they recognised the pressures of staffing which compromised the time staff had available to give individual care. A patient on one of the G level wards said “the nursing staff are brilliant, they work so hard with little respite”

We received positive feedback directly from patients. We observed on all the wards thank you cards from patients and/or their relatives all expressing their thanks for the care and treatment provided.

A patient on one of the F level wards described their care as “very good; fast diagnosis and treatment, and staff were very friendly”. Another patient commented “I’ve been so well looked after; instant and caring response to any request when using my call bell for help.”

Staff on the respiratory high care ward demonstrated a commitment to providing holistic care to their patients. They described knowing many of their patients very well, as many had long term respiratory conditions and had frequent admissions to the unit. Staff described strong links with the community and hospital palliative care team.

We observed staff interactions with patients throughout the medical care service showed compassion and care. This included non-clinical staff, such as domestic and administrative as well as clinical staff across all locations.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The friends and family test (FFT) response rate for medicine at the trust was 32% which was better than the England average of 24% from June 2018 to May 2019. The FFT showed that for most wards 90% to 100% of patients who responded recommended the ward as a place to receive treatment.

A breakdown of FFT performance by ward for medical wards at trust level over this time period is shown below.
Friends and family test – Response rate between 01/06/2018 to 31/05/2019 by site.

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. 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.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. We saw staff demonstrating empathy when having difficult conversations, and staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. There were arrangements for open visiting on the wards we visited, staff felt this was best to support patients care and treatment.

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

All wards we visited used symbols above bed spaces to indicate what support maybe needed, for example, patients with dementia or end of life care, and for different physical support such as help at meal times. The symbols were used to inform staff without revealing the individual needs of the patients to visitors who were not part of the healthcare team.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
In our previous inspection, our conversations with patients showed mixed experiences as to whether they were kept well informed about their care and treatment. During this inspection patients told us they were kept informed and were involved in decisions about their care, and where they had wanted to, their families were included in their care planning. Information leaflets were made available to relatives and friends and regular information and educational sessions were available at the hospital.

Staff made sure people who used services and those close to them could find further information, including community and advocacy services, or ask questions about their care and treatment. Ward rounds we saw were unhurried and allowed patients enough time to discuss their care and treatment.

Staff told us they understood the impact some illnesses and conditions had on the whole family, not just patients, and always involved relatives and carers in as many aspects of care as they could.

The Patient Led Assessment of the Care Environment (PLACE) August 2018 audit included privacy, dignity and well-being, and showed that the trust achieved a similar score to the average for England as a whole.

<table>
<thead>
<tr>
<th></th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privacy, dignity and well-being %</td>
<td>83.24</td>
<td>84.16</td>
</tr>
</tbody>
</table>

We saw staff support individuals living with dementia, we saw that they were comfortable the way staff spoke with them, the staff demonstrated genuine affection, care and concern for individuals.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw examples of ‘you said, we did’ boards on wards displaying the feedback and changes made.

Staff supported patients to make both advanced decisions and informed decisions about their care. We observed care and treatment being explained to patients and their families in detail for patients to provide consent.

### Is the service responsive?

#### Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

At previous inspections of the medicine and urgent care division there were a number of concerns. We found patients were not consistently cared for in same sex accommodation areas; the endoscopy service had lost its’ accreditation because of this issue. At the time of this inspection we saw construction work to address this issue in endoscopy.** In other areas staff were able use bays more flexibility to cohort male and female patients separately, and ensure washing facilities were properly located for the patients using them.
The trusts Capacity Management policy that included escalation measures (October 2017) set out the actions staff needed to take and areas of the hospital that the service could use as escalation areas in the event of capacity issues. This policy was now fully embedded with 60% of admissions going to the correct specialty base ward. When this was not possible patients were outlined to a ‘buddy’ ward; each outlying ward (surgical) knows exactly which medical wards and teams it is dealing with. Each medical specialty has responsibility for outliers in a maximum of only three wards.

Ward D2 admits patients predicted as short stay and unlikely to require consultant geriatrician input. 90% of these patients are discharged home often staying on the ward for less than 12 hours.

Step down models of care were implemented so patients could be transferred quicker from high dependency beds, and weekend ward rounds were done by more specialties: cardiology, respiratory, gastroenterology, care of the elderly. We learned that up to 100 patients may be discharged on a Saturday.

However, staff in the stroke unit told us there were never enough beds, on the day of our visit 12 beds were occupied by general medicine patients, which meant that a patient elsewhere in the hospital who had a stroke could not be transferred to the unit.

The trust had a learning disability nursing team which worked across the hospital to support patients with a learning disability. The team provided assessment, advice and support to staff, patients and carers. We saw evidence of frequent contact between the learning disability liaison team, patients and ward staff.

** After the inspection the trust informed us that the building work was completed at the end of November as planned.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff assessed patients’ individual needs using proformas designed to capture information on mental health status, dementia, learning difficulties and any other disability. Information was shared at daily safety huddles and handovers, and highlighted using symbols on magnetic patient information boards. This information was also displayed on patient name boards in the bed space so that all staff understood what the specific patient needs were.

We saw good use of the ‘red tray, system to identify patients who needed help at meal times, though not all patients requiring support were identified in their bed space

We saw staff cohort patients who wandered in smaller bays. An extra staff member was allocated to these bays to enable closer monitoring.

The National Audit of Dementia Care in General Hospitals 2016 – 2017 carried out by the Royal College of Psychiatrists and published in July 2017 identified the trust as one of the poorest performing trusts for care of patients with dementia. The trust had one of the worst performances for carer rating of information and communication and carer rating of patient care. The 2018 Audit report was published in July 2019, the audit was undertaken by the trust senior lead nurse for dementia and end of life care. There were some improvements evident, and
recommendations had been made to address the areas for further improvement. The trust had made some changes to the wards for older peoples’ medicine to make them more ‘dementia friendly and ward G4 had a memory lane activities room with dementia televisions. Patients living with dementia were able to use reminiscence boxes and twiddle muffs which helped some patients to stay calm and reduce anxiety. The activities co-ordinator had recently left the trust, but at the time of our inspection, funding had been secured to recruit to the post again.

The trust provided the ‘Portsmouth Hospitals Learning Disability Protocol’. This was originally developed in 2014, and updated in May 2019 by the learning disability liaison nurses. The document contained clearly documented care pathways for in patients and out patients with a learning disability. Staff we spoke with were positive about the training they received about learning disabilities and the support provided by the liaison team.

We saw evidence in the care records of personalised assessments and care plans. Where able to, patients had given details about their preferences, likes and dislikes. There was evidence of relatives contributing to identifying their relative’s needs and ensuring care was personalised and responsive.

Therapy was provided in a patient centred way. For example, patients recovering from a stroke had prescribed activities which were monitored and data collected nationally. Results were published to give an indication of how national guidelines were met. Staff provided this therapy according to the needs of the patients and judged how much the patient could cope with.

We saw a sensory trolley in the respiratory ward for a patient with severe learning disabilities. He was very happy with the fibre optical sensation and the image projection to mimic the inside of an aquarium.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

We saw there had been definite improvement with flow across the hospital and staff could demonstrate this. There was more of a connection from the front door to the ward, and visibility of where people were. Operational meetings took place at 08.30; 13.00; 16.00; 17.30; 19.00. Staff used a bespoke electronic system to view and manage the bed spaces available. Medical outliers number between 40 and 50 on a daily basis. At the time of our inspection, overall bed occupancy was 95%, but for general medicine and care of the elderly it was 98-99%. The operational team was led by the Chief Operating Officer whose aim was to manage occupancy down to a safer 92%. Staff explained the changes to the system over several years, the results were seen to be constantly improving and staff felt the current state was the best it has ever been.

The ambulatory care team diverted 35% of the prospective medical admissions. The physician of the day now included more different specialties, including renal and rheumatology, and the consultant was available from 08.00 until 22.00. On the day of our visit to the ambulatory care ward there were four beds occupied by patients who were admitted the previous evening. These patients were prioritised for transfer to suitable wards or discharge as their presence was impacting on patient flow, but we saw this was well managed.
This team also had band 6 nurses who managed a DVT clinic. Patients received a full assessment including blood tests and a scan, which often meant that patients were able to receive treatment without the need to wait to see a doctor.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards and worked to minimise the number of medical patients on non-medical wards. There was a management plan for medical outliers and staff were aware of where these patients were within the hospital bed base. Overnight there were three registrars on duty and, at the time of our visit, 86% of new patients were reviewed by a consultant within 14 hours of arrival.

We saw the initiatives taken to promote discharges early in the day. Junior doctors were involved in audits, presentations and road shows, and encouraged to do discharge summaries and take home medicines the day before the patients went home. There was a ward accreditation scheme but accreditation was only possible if there was successful early discharge. The monthly and quarterly metrics showed that this message was becoming embedded. The peak discharge hour was gradually moving from the evening towards the morning. Staff felt that if this trend continued it suggested that, within 6 months, the hourly bed need would not exceed the hourly bed availability.

Ward sisters and matrons on the older peoples’ medicine wards attended daily leadership and flow meetings to consider staffing and flow, and any barriers to discharges.

At previous inspections the cardiology day unit had been significantly impacted by the pressure on beds within the hospital and it had been used frequently as an escalation area for inpatients. The unit could sometimes be filled with 3-14 patients overnight for two to four days in any given week. The patients were usually unselected general medical patients who sometimes stayed for several days, thus preventing the unit from serving its primary function for the catheter laboratories, and forcing staff to restrict their lists. At the time of this inspection the problem had been overcome by an agreed list of criteria for the admission of escalation patients. Criteria required patients to be stable with a cardiology problem where, after early review by a cardiologist, they were fit for discharge the next morning. Staff told us this was proving to be much less of an impact for their day to day service.

The trust had comprehensive discharge policy which set out the process requirements and staff responsibilities to support well-organised, safe and timely discharge for all patients. It aimed to fully involve patients and their carers/relatives in the discharge process and ensure that patients received appropriate assessment, planning and information about their discharge and after care.

The integrated discharge team helped supported complex discharges. They were responsible for co-ordinating available beds in the community or packages of care for patients to be discharged safely. They were responsible for improving planning to facilitate earlier discharge and thus patient outcomes.

**Average length of stay**

From March 2018 to February 2019 the average length of stay for medical elective patients at Queen Alexandra Hospital was 4.0 days, which was lower than England average of 5.9 days. For medical non-elective patients, the average length of stay was 8.1 days, which was higher than England average of 6.1 days. The data for this division had improved on the previous year.

Average length of stay for elective specialties:

- Average length of stay for elective patients in Cardiology was lower than the England average.
• Average length of stay for elective patients in Nephrology was lower than the England average.
• Average length of stay for elective patients in Gastroenterology was lower than the England average.

Elective average length of stay - Queen Alexandra Hospital

Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

• Average length of stay for non-elective patients in General medicine was higher than the England average.
• Average length of stay for non-elective patients in Cardiology was higher than the England average.
• Average length of stay for non-elective patients in Nephrology was higher than the England average.

Non-elective average length of stay - Queen Alexandra Hospital

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

In June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was lower than then England average. From July 2018 to May 2019, it was about the same as the England average.
Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100.0%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>98.0%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.9%</td>
<td>81.0%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>86.7%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>71.3%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>63.6%</td>
<td>81.1%</td>
</tr>
</tbody>
</table>

Patient moving wards per admission

From June 2018 to May 2019 all medical patients moved wards at least once during their admission. Additionally, 2.8% of patients moved wards twice or more during the same period.

Patient moving wards at night

From June 2019 to May 2019, there were 1,376 patients moving wards at night within medicine.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However response times to complaints were not in line with the hospital policy.

Summary of complaints

Trust level
At the time of our previous inspection the trust had received 240 complaints within the reporting year relating to the medicine core service. From June 2018 to May 2019 the trust received 161 complaints about medicine (22.1% of total complaints received by the trust). This was much improved on the previous report.

However the trust took an average of 50.9 days to investigate and close complaints, which was almost 4 days longer than the previous inspection, and was not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

The trust monitored complaints through the monthly integrated performance report. The complaints team maintained contact with and provided information to complainants and overdue complaints were monitored through the trust leadership team and divisional performance reviews. Managers were aware that their compliance against this key performance indicator was poor but their efforts to improve was hampered by operational challenges. Complaints in medicine were reviewed at weekly safety meetings and at the end of month divisional review so that themes could be discussed and shared at safety huddles.

In order to try and prevent some formal complaints matrons made themselves available on the wards at main visiting times in order to be available for families to discuss and address any concerns. Staff on ward D7 have offered time slots for families to meet with doctors during ward rounds.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>51</td>
<td>31.7%</td>
</tr>
<tr>
<td>Admissions / transfers / discharge procedure</td>
<td>24</td>
<td>14.9%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>23</td>
<td>14.3%</td>
</tr>
<tr>
<td>Communication (oral)</td>
<td>20</td>
<td>12.4%</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>11</td>
<td>6.8%</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>10</td>
<td>6.2%</td>
</tr>
<tr>
<td>Date of admission / attendance (Inpatient)</td>
<td>4</td>
<td>2.5%</td>
</tr>
<tr>
<td>Patient privacy / dignity</td>
<td>4</td>
<td>2.5%</td>
</tr>
<tr>
<td>Personal records</td>
<td>4</td>
<td>2.5%</td>
</tr>
<tr>
<td>Competence</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Bed shortages</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Policy &amp; commercial decisions of NHS board</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Failure to follow agreed procedures</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Access to Treatment</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Shortage / availability</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Patient status</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Consent to treatment</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Communication (written)</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>161</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From June 2018 to May 2019 there were 1,998 compliments about medicine at Queen Alexandra Hospital.

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

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Specialist medical services, older peoples’ medicine and the acute medical unit all sit within the medicine and urgent care division, whilst renal medicine and cancer care sit within the networked services division. Each division was led by a divisional medical director, divisional operations director, and a divisional nurse director.

The trust had restructured from 11 clinical service centres into four divisions since our previous inspection in the spring of 2018. The leadership team for specialist medical services and older peoples’ medicine had worked together for more than a year and demonstrated a close working effective relationship. They had a comprehensive knowledge of current priorities and challenges and took action to address them, and felt that the restructure had enabled improved joint working between specialisms. As leaders, they had a shared purpose and better understood the strengths and weaknesses of the different groups,

The biggest challenge was staff recruitment and retention. The leadership team described their recruitment programmes and strategies for developing their own staff and offering development opportunities. The leadership team felt they received support from the board and staff also felt support was provided, although this was dependent on board priorities. From a recruitment perspective we were told the board had encouraged pursuing recruitment world wide where this was practical and ethically acceptable.

Regular meetings were held by the leadership team focussing on quality and performance, and they had developed improved working with GP partners and the commissioners, particularly through the integrated discharge team.

Staff we spoke with described all levels of leaders as visible and contactable, they felt supported and listened to by their managers and felt they could raise any issues or concerns they had. Freedom to speak up guardians were available for staff if they were concerned about raising issues to their managers and wanted to remain anonymous.

Nurses at band 6 level on the older peoples’ medical wards were encouraged to access the aspiring leader programme.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust vision set out the purpose of the organisation “Working together, to drive excellence in care for our patients and communities”. This was underpinned by four values: working together for patients; working together with compassion; working together as one team; working together, always improving.
The trust launched an organisational ‘Working Together’ strategy in July 2018. Underpinning the strategy are five strategic aims to:

- Fulfil a role for the local communities.
- Support safe, high quality patient focused care.
- Take responsibility for the delivery of care now and in the future.
- Invest in the capability of staff to deliver the vision.
- Build the foundations on which teams can best deliver care.

The leadership team for the medicine and urgent care division described how leaders throughout the trust used these aims to develop and align their services with the trust strategic direction. The leadership team reflected on the last eighteen months and described the focus on recruitment and quality improvement projects for the division in particular. We saw most wards displayed the trusts values, staff knew and understood the vision, values and strategy and how achievement of these applied to the work of their teams and many were keen to be involved in the quality improvement projects. The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. There were divisional strategic aims, but a recognition of the strategic challenges.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was evidence of a multi-professional and collaborative culture within the division, appreciating the joined up working and expertise individuals brought to roles and services.

The leaders told us the culture of the division had positively changed, and staff had a better understanding of the emergency pathways and the impact across the division. The collaboration between teams to focus on improving patient pathways and flow was evidence of this.

Staff felt respected, supported and valued. They felt positive and proud about working for the trust and their team. All staff we spoke with had a positive attitude about working together, were passionate about care, and were proactive about their engagement with quality improvement projects for the benefit of the patients. They felt supported in their roles by senior staff, and all grades and roles of staff felt they were an important part of the team.

Staff knew about Freedom to Speak Up Guardians and their role, but those we spoke with felt able to discuss concerns with their line managers and had not accessed this support.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The restructure eighteen months previously had led to the development of effective structures, systems and processes to support the delivery of quality care and treatment. We found the clinical group leadership understood the importance of governance and recognised the value of a standardised approach. All the staff we spoke with confirmed there was a good structure in place across the divisions with meetings attended by both divisional leads and senior staff.
Each specialty had arrangements for their governance and could explain how this reported to the divisional governance meetings. Divisional clinical governance fed in to the clinical divisional management boards and then to the trust management team who reported to the quality groups and trust board. We reviewed example minutes and saw actions were recorded and followed up.

Mortality and morbidity reviews were completed at specialty level and reported to divisions. Avoidable harm cases could then be discussed at the trust wide monthly mortality and morbidity group for learning to be fed back to the trust board.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. Staff could confidently talk to us about their involvement in governance.

The divisional performance and accountability monthly review reflected the focus on quality and improvement within the division. For example, the stroke improvement trajectory, and long term endoscopy plan.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were systems to identify learning from incidents, complaints and safeguarding alerts and make improvements.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their ‘worry list’. Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. We reviewed the divisional risk register and saw risks matched concerns. Leaders on the wards and within specialties had a good understanding of their risks and how to manage them.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. When talking through audits leads were clear on their performance, and where improvements were needed.

Since our last inspection there was a better oversight and co-ordination of patient flow within the hospital. Flow was reviewed regularly with relevant people, and there were clear actions and updates discussed within the meetings. Improving flow has been tackled at many points in the pathway. Improved processes within the emergency department and ambulatory care, along with the introduction of the ‘physician of the day’ has ensured that 86% of new patients were reviewed by a consultant within 14 hours.

Initiatives have been taken to promote discharges early in the day. Junior doctors have been involved in audits, presentations and road shows, and encouraged to do discharge summaries and patient take home medication the day before.

We reviewed the monthly performance reporting pack; this clearly reflected the issues that the staff we spoke with discussed, and we could see the actions to mitigate risks with next steps to improve performance.
Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. The information technology systems were used effectively to mange patient flow through the hospital.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Key performance indicator dashboards and assessments were held for each division. This reviewed quality, workforce, finance and responsiveness.

Monthly audits of patient safety outcomes were displayed for staff and motivated them to improve on any that did not meet the targets. Patient feedback information was also discussed to identify areas of good practice and areas, which required improvement.

Notice boards at entrances to wards showed information for patients, for example, results from hand hygiene audits, level of falls and a cleaning analysis. Information for patients was easily available to patients on all wards. Information leaflets were available on all wards.

Patients individual care records were stored securely. Medical records were stored in locked trolleys, or when in use were not left unattended.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

At previous inspections we identified poor staff engagement, during this inspection we found a much improved situation, as all staff we spoke with were happy that managers and executives were listening to them. They told us how the chief executive (CEO) communicated with staff through regular emails, weekly messages posted on the trust’s intranet and internet. We learned that the CEO had visited many wards and supported staff to deliver care and understand the challenges for their particular specialty.

In April 2019 the division opened discussions with staff about the use of restraint, and reported good levels of engagement from staff, this led to a staff survey around violence and aggression. A staff event was held on World Patient Safety Day which engaged staff, who made pledges on what actions they would take to reduce patient harm. The pledges were broken down into themes to feed back to the wards.

Results of a staff pulse survey for the division presented in May 2019; showed a number of the metrics where scores for staff in the medicine care group and the older peoples’ medicine(OPM) were worse that the trust wide score. For example, staff experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in the last 12 months was 52 in OPM and 41 in medicine compared with trust wide 29. Staff in the medicine and urgent care division felt that they had unrealistic time pressures; scoring 43 in the division against a trust wide score of 32. The atmosphere in most of the wards and areas that we
visited did not reflect this. Staff did report that they could deliver improved care if there were more staff but they knew that managers were supportive of them and adjusted staffing levels to meet demand. Staff across all the wards for older peoples’ medicine described how they worked to support each other.

We saw minutes from the staff well-being council which met approximately every eight weeks. Items discussed included ideas to support staff, for example a juice round to make sure staff always had a drink, and coffee meetings to enable staff to share ideas and support. Items also included ideas to support staff in improving care and comfort for patients.

The division used the friends and family test (FFT) to capture patients’ feedback and we saw that FFT ‘would recommend’ was high in specialist medicine and older peoples’ medicine. We saw that staff received many ‘thank you’ cards and complements about the service provided, these were displayed throughout the wards.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.*

The senior team had developed a new role to manage the stroke pathway, including the acute and community teams, to improve communication and continuing care. There was a programme to upskill nurses in stroke care to undertake swallowing assessments.

The division used the friends and family test (FFT) to capture patients’ feedback and we saw that FFT ‘would recommend’ was high in specialist medicine and older peoples’ medicine. We saw that staff received many ‘thank you’ cards and complements about the service provided, these were displayed throughout the wards.

The trust worked closely with NHS improvements (NHSI) from August 2018 to February 2019 to develop bespoke work around leadership. This was delivered in an intense coaching style to many staff from band 6 upwards.

There were lots of quality improvements delivered as small projects. For example, Wessex leadership for band 7 nurses; focus on safety and flow for emergency nurse practitioners in AMU.

A nurse-led deep vein thrombosis (DVT) clinic workstream in the ambulatory care unit as part of the NHSI accelerator course.

In the cancer care wards a ‘demystifying chemotherapy’ session is offered to patients before admission. The session is run on Thursday afternoons once a fortnight.

Nurses in respiratory care have developed a teaching package to inform ward staff and others involved in the urgent care pathway about the specific needs of a particular group of patients requiring ventilation.

The new frailty assessment unit includes a fully multidisciplinary team who make timely patient assessments to ensure the patients receive the right care in the right place.

The division has successfully introduced SWARMs, a form of safety incident huddle, allowing immediate action and enhancing organisational safety culture, enabling a quick response to a patient safety incident.
Facts and data about this service

Portsmouth Hospitals NHS Trust provides district general hospital surgical services at the Queen Alexandra Hospital. The surgical specialties offered at the hospital are colorectal, urology, breast and plastics, lower and upper gastrointestinal (digestive), vascular (vein) surgery, bariatric (patients with a high body mass index) and general surgery.

The trust has a large orthopaedic centre, providing elective and emergency trauma surgery. In addition, there is a musculoskeletal (MSK)/head and neck care group at the trust also providing ophthalmic (eye) surgery, dental, maxillo-facial and oral surgery. Dermatology (skin) services which require minor surgical procedures are provided off site at St Mary's Hospital.

(Source: Routine Provider Information Return (RPIR) – Sites tab, trust website)

The trust had 46,216 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 13,744 of these (29.7%), 26,369 (57.1%) were day case, and the remaining 6,103 (13.2%) were elective.

(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

The service provided mandatory training in key skills to all staff.

Nursing staff received and kept up-to-date with their mandatory training. However, medical staff did not always keep up-to-date with mandatory training. We discussed this with senior leaders, who told us they were investigating the reasons for this. They told us medical staff sometimes struggled to attend face-to-face mandatory training courses due to the clinical needs of the service. Senior leaders told us they were actively encouraging medical staff to complete their mandatory training during protected learning sessions to improve training compliance. Divisional governance meeting minutes we reviewed showed senior leaders regularly monitored training rates.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from 1 April 2019 to 21 July 2019 at trust level for qualified nursing staff in surgery is shown below. Figures for qualified nursing staff are the same at both the trust and Queen Alexandra Hospital, therefore only the trust-level figures are presented below.
In surgery the 85% target was met for 13 of the 14 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from 1 April 2019 to 21 July 2019 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>284</td>
<td>299</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>284</td>
<td>299</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>271</td>
<td>299</td>
<td>90.6%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>271</td>
<td>299</td>
<td>90.6%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>261</td>
<td>299</td>
<td>87.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>253</td>
<td>299</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>243</td>
<td>299</td>
<td>81.3%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicine management training</td>
<td>72</td>
<td>92</td>
<td>78.3%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>211</td>
<td>275</td>
<td>76.7%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>222</td>
<td>293</td>
<td>75.8%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>212</td>
<td>296</td>
<td>71.6%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>205</td>
<td>296</td>
<td>69.3%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>195</td>
<td>293</td>
<td>66.6%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>76</td>
<td>151</td>
<td>50.3%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In surgery the 85% target was met for five of the 14 mandatory training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff knew how to identify patients at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to give examples of times they had correctly identified and reported safeguarding concerns. Surgical staff made 143 safeguarding referrals in the inspection reporting period, June 2018 to May 2019. The musculoskeletal (muscles, joints and bones) service had two safeguarding leads who supported staff in raising safeguarding concerns. The musculoskeletal safeguarding leads were visible on the wards, and staff were able to identify them.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from 1 April 2019 to 21 July 2019 at trust level for qualified nursing staff in surgery is shown below. Figures for qualified nursing staff are the same at both the trust and Queen Alexandra Hospital, therefore only the trust-level figures are presented below.

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>407</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>465</td>
</tr>
<tr>
<td>Prevent Basic Awareness</td>
<td>456</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>452</td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>386</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>379</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>14</td>
</tr>
</tbody>
</table>

In surgery the 85% target was met for six of the seven safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from 1 April 2019 to 21 July 2019
at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>258</td>
<td>270</td>
<td>95.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>283</td>
<td>299</td>
<td>94.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>243</td>
<td>299</td>
<td>81.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Basic Awareness</td>
<td>229</td>
<td>299</td>
<td>76.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>37</td>
<td>50</td>
<td>74.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>173</td>
<td>296</td>
<td>58.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>170</td>
<td>296</td>
<td>57.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 85% target was met for two of the seven safeguarding training modules for which medical staff were eligible.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff followed infection control principles including the use of personal protective equipment. All staff were ‘bare below the elbows’ in clinical areas to allow effective handwashing in line with national guidelines. In the operating theatres, staff wore scrub suits and theatre caps in line with trust policy.

Ward areas and theatres were visibly clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Theatres were visibly clean and tidy. We reviewed cleaning checklists for theatres, which provided assurances staff had completed daily and weekly cleaning tasks.

Monthly cleaning audit results provided assurances around the cleanliness of theatres and wards. Hand hygiene audits provided assurances around staff compliance with hand hygiene practice. Cleaning and hand hygiene audit results were displayed in clinical areas. We reviewed the audit results for August 2019 on wards D1, D8 and the Surgical Assessment Unit. Hand hygiene results ranged between 96% and 100%, and cleanliness audits scores were between 95% and 98%.

None of these three wards reported any infections of Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. diff; a bacterium that can infect the bowel and cause diarrhoea) during this period. Infection prevention and control notice boards on the wards displayed cleaning schedules and contact information for the trust infection prevention and control team.

Staff worked effectively to prevent, identify and treat surgical site infections. The service worked to prevent hospital-acquired infections and screened patients for Methicillin-resistant Staphylococcus aureus (MRSA) before surgery. The pre-assessment appointment included swabs to test for...
MRSA so staff could treat this before surgery if the results came back positive. In theatres, patients identified as carrying MRSA had their operation last on the list to allow time for a deep-clean of the theatre. The surgery and outpatients’ divisional performance dashboard showed the service had no cases of MRSA bacteraemia (bloodstream infection) in the period September 2018 to August 2019. The service followed Public Health England’s national ‘Protocol for the Surveillance of Surgical Site Infection’. The most recent surgical site infection data provided by the trust showed an infection rate of 1.2% for total knee replacements in the period April to June 2019. This was an improvement on the rate of 2.2% reported for the period October to December 2018.

The service had an onsite facility for the sterilisation of surgical instruments. The Hospital Sterilisation and Disinfection Unit was a medical device directive and an International Organisation for Standardisation (ISO) 13485 accredited facility. The British Standards Institution assessed the unit every six months to demonstrate decontamination was in line with national standards. The trust reported that the service’s assessments over the past 12 months were positive. The service met their four-hour target turnaround times for instruments. Theatre staff told us there were no problems obtaining instruments in a timely way for operations.

We visited the Hospital Sterilisation and Disinfection Unit and saw ‘dirty’ and ‘clean’ instruments were properly segregated, with the flow of instruments in one direction to prevent cross-contamination. Staff wore personal protective equipment and stayed in the same area for their whole shift. This meant staff did not move from ‘dirty’ to ‘clean’ rooms to prevent cross-contamination. The service used a traceability system, which allowed the tracking of instruments through the department, and to individual patients. When collecting used sets of instruments from theatres, staff checked instruments against the instrument tray list. If any instruments were missing, the theatre team arranged an X-ray to check whether the instrument had been retained inside the patient. This had not happened during the reporting period for this inspection.

Staff allocated side rooms to patients with transmittable infections to reduce the risk of cross infection. Staff put signs on the doors to alert colleagues to the infection risk and personal protective equipment and alcohol hand gel were available outside side rooms.

On the Surgical High Care Unit, there were no side rooms available for patients who needed isolation. The service used measures to reduce the risk of cross-infection. For patients with non-airborne infections who needed a bed in the unit, staff allocated a bed at the end of the ward next to a hand wash basin and used screens for patients needing isolation to minimise the risk of cross-infection. The brand of screens used by the service were designed to bring effective isolation to patients with non-airborne infections. Staff in the surgical high care unit liaised with the trust’s infection prevention and control team on a case-by-case basis for any patients with infections. Hand wash basins and personal protective equipment were available in the bays, and alcohol hand gel was readily available at each bed space on the Surgical High Care Unit to allow staff to clean their hands before and after each patient contact. The service deep-cleaned premises and equipment that came into contact with patients with infections. Data showed the Surgical High Care Unit accommodated 27 patients with infections in the year before our visit.

The Surgical High Care Unit’s acceptance policy did not accept patients with airborne infections due to the lack of side rooms. However, the service cared for six patients with airborne infections on the Surgical High Care Unit in the year before our visit. Of these, five patients had Clostridium difficile (C. diff; a bacterium that can infect the bowel and cause diarrhoea), and one had influenza. This was not in line with the acceptance policy. The service recently worked to strengthen compliance with their acceptance policy for the Surgical High Care Unit. We saw that they added
information to the referral form clearly stating the unit would not accept patients with airborne infections. However, it was too early to measure the impact of this change.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe.** Staff were trained to use equipment and carried out daily safety checks of specialist equipment. The service had enough suitable equipment to help them to safely care for patients.

The service tested equipment to provide assurances around function and electrical safety. Engineers labelled equipment to show when it was last tested. We checked 29 randomly selected items of equipment across five wards (E2, E3, D8, Surgical High Care Unit and Surgical Assessment Unit). All 29 items passed an electrical safety test within the last 12 months.

Staff checked and maintained emergency resuscitation equipment, so it was ready for use in an emergency. We checked four emergency resuscitation trolleys on ward E2, Surgical High Care Unit, Surgical Assessment Unit and in main theatres. On all four trolleys, records showed staff completed daily checks, providing assurances the trolleys were safe and fit for purpose. We checked sterile items and intravenous fluids in all trolleys and saw all were sealed and within the manufacturer’s expiry dates.

In ward areas, we noticed the resuscitation trolleys did not have a tamper evident tag, and instead, emergency medicines were kept in a sealed box on the trolley. The medicine boxes on the Surgical High Care Unit and ward E2 had some dust on the top, and these were not included in the daily cleaning tasks. The separate medicine boxes also presented a risk that they could be stolen from the trolley, however, the risk of this was much lower than the medicines not being available for use in an emergency. The cardiac arrest “crash team” may be called to any area of the hospital and would not be familiar with the ward or clinic area when they arrived so it was important that the medicines were easily accessible. The trust’s medicines management policy states, “Medicines for the emergency management of patients are exempt from the requirement for storage in a locked cupboard, but are supplied with tamper-evident seal, which should remain intact”. The storage of emergency medicines in surgery complied with this policy, which was in line with Resuscitation Council guidance.

Staff checked critical equipment in theatres every day and kept records to show they had done this. Staff checked anaesthetic machines in theatres daily and logged electronically that they had completed the required checks before the start of the operating list.

The service managed clinical waste well. Staff correctly segregated clinical and non-clinical waste into different coloured bags. This was in line with the Department of Health’s Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste. Staff used designated recycling bins for disposal of recyclable non-clinical waste to help the environment. The service disposed of sharps items such as needles, safely in line with the Department of Health’s Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste to protect staff and patients from accidental injury. Designated yellow-lidded sharps disposal bins were correctly assembled, dated and closed before they were more than three-quarters’ full.

The service had suitable equipment for treating bariatric patients (patients with a high body mass index). This included bariatric-capable operating tables and two bays in theatre recovery with bariatric trolleys.
Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff identified and quickly acted upon patients at risk of deterioration. This was an improvement from our previous inspection in April 2018, when staff did not always complete comprehensive risk assessments or develop risk management plans in line with national guidance.

Theatres followed the World Health Organisation (WHO) Surgical Safety Checklist to ensure patients received their operation safely. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre) and debrief.

We observed all five steps of the WHO checklist, and saw staff fully completed and engaged in all the required checks. The service had acted on concerns we raised at our previous inspection in April 2018 around poor staff engagement with the WHO checklist, as well as learning from never events arising from checklist errors. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

The service audited compliance with the WHO Surgical Safety Checklist through a combination of checking patient records and senior staff observations in theatres. We reviewed the trust’s ‘WHO checklist quality audit summary report’ for 2018-19 (dated 11 July 2019). This showed staff performed all five steps of the checklist on 100% of occasions. However, the audits also looked in detail at the quality of compliance with all elements of each step. This identified occasional deviations from following the standardised template and policy guidance on how the checklist should be carried out. Overall compliance with performing every element of every step in the correct manner was 93.3%. The audit had a clear action plan, and we saw progress with implementation of actions during our inspection, such as improvements in ‘stop and listen’ moments.

Staff used National Early Warning Scores 2 (NEWS2), a recognised tool to identify deteriorating patients, and escalated correctly in line with national guidance. We reviewed nine patients’ National Early Warning Score charts and saw staff recorded observations and calculated early warning scores correctly. Staff escalated for urgent medical review where clinically indicated in line with national guidance.

The service used systems to recognise and treat sepsis (severe blood infection) in line with national guidance. Sepsis is a rare but serious complication of an infection that can lead to multiple organ failure and death if not treated promptly. We saw the trust’s “Inpatient Sepsis Screening and Action Tool”, which staff used when observations triggered sepsis screening. The service used a mobile software information system to record patient observations. The system flagged patients that might be developing sepsis and prompted staff to commence sepsis screening. The action tool provided clear flowchart guidance for staff in line with the national ‘Sepsis Six’ pathway to diagnose and treat sepsis. A nurse on ward D8 described a recent occasion when staff followed the pathway and treated sepsis in a patient who developed it from tonsillitis.

Staff completed risk assessments for each patient on admission (and pre-admission for elective surgery) using recognised tools. We observed one patient undergoing nurse-led pre-assessment and saw this was a thorough process that identified risks before surgery. Pre-assessment nurses informed patients of an out-of-hours emergency telephone number they could call should they
develop any concerns after discharge, as well as providing a ‘patient passport’ with written information.

We reviewed nine sets of patient notes and saw completed risk assessments for falls, pressure ulcers and venous thromboembolism (VTE, or blood clots in veins). The service took action to reduce identified risks, such as prescription of anticoagulants (anti-clotting medicines) and compression stockings where clinically indicated to reduce the risk of venous thromboembolism. Patients at risk of falls wore non-slip socks, and staff used ‘foot’ magnets above patients’ bed spaces to highlight patients at increased risk of falls who might need observation or assistance when mobilising.

Staff updated assessments when necessary. We saw staff attend to two patients who fell on wards E2 and E3 during our visit. Doctors attended to review the patients, and nursing staff commenced neurological observations for a patient who injured their head when they fell in line with trust policy. Nursing staff promptly completed falls reassessments for both patients that fell to identify risk factors and actions to reduce the risk of further falls.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health. Staff knew how to contact the team for support.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

In theatres, we saw the service staffed operating lists in line with the Association for Perioperative Practice guidance. The Association for Perioperative Practice recommended minimum theatre staffing levels of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner for each theatre list. Theatre staff numbers exceeded the establishment, and therefore bank and agency use was minimal and limited to covering holidays and staff sickness. Many theatre agency staff had joined the trust’s staff bank, which further reduced agency use.

Following a successful overseas recruitment campaign, vacancy rates for nurses and healthcare support workers on the wards had reduced in the year before our visit. Where the service used agency staff, we saw records showing staff had an orientation to the ward and checks of Nursing and Midwifery Council registration, training and competencies.

During our visit, actual staffing levels usually met planned levels. However, we saw there were still some shifts where they were short of one member of staff. Nursing staff on the wards described how they were always “busy”. The service sometimes moved staff with the right skill mix to a different ward to fill shifts if one area was particularly busy on a given day. This helped maintain safe staffing levels. Staff described how they worked flexibly to cover shifts and demonstrated a willingness to support their colleagues on other surgical wards.

Trust level

The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust’s targets, where applicable. Figures for qualified nursing staff are the same.
at both the trust and Queen Alexandra Hospital, therefore only the trust-level figures are presented below.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1,413.8</td>
<td>7%</td>
<td>11%</td>
<td>3.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>486.2</td>
<td>16%</td>
<td>11%</td>
<td>3.9%</td>
<td>36,422 (35%)</td>
<td>36,604 (35%)</td>
<td>31,367 (30%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use.

Following the inspection, the trust provided updated data for nursing staff, which showed that for the period November 2018 to October 2019, there was a downward shift in sickness between April 2019 and September 2019 and an upward shift in agency hours at trust-level from May 2019 to October 2019.

The table below shows a summary of the updated nursing staffing metrics in surgery trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate*</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1,425.5</td>
<td>6%</td>
<td>10%</td>
<td>3.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>480.3</td>
<td>13%</td>
<td>12%</td>
<td>3.7%</td>
<td>43,508 (40%)</td>
<td>480.3</td>
<td>13%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs) * Please note that sickness data was provided for the time period October 2018 to September 2019
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change.

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

Agency staff usage

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives shows a shift from December 2018 to May 2019.
Following the inspection, the trust provided updated data for nursing staff, which showed that for the period November 2018 to October 2019, there was an upward shift in agency hours at trust-level from May 2019 to October 2019.

Monthly agency hours over 12 months for qualified nurses, health visitors and midwives shows a shift from November 2018 to June 2019.

Medical staffing

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

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Records showed evidence of daily ward rounds, including review with senior clinicians. The Surgical Assessment Unit had cover from two consultants, two registrars, two senior house officers and two first-year junior doctors on day shifts. At night, there was one registrar, one senior house officer and one junior doctor, with consultant on-call cover.

Nursing staff on the wards told us there were no problems in finding a doctor to review any patient that needed urgent medical review. Medical outliers (medical patients occupying surgical beds) received a daily review by an allocated medical team. Nurses reported senior house officers on the surgical wards promptly reviewed any medical outliers if there were any urgent concerns. A matron described how there had been a positive “culture change”, and the feeling amongst medical staff was that if a patient was “on the ward and poorly, they are our patient”, regardless of whether they are a medical or surgical patient. Ward D8 had a “buddy” bleep system with some of the medical wards. This meant nursing staff on the ward knew who to contact to request a doctor to review a medical patient. Staff had a list of bleep numbers and ward telephone numbers. Nurses told us they could easily contact doctors in the relevant area to review any medical outliers if needed.

The trust had identified a risk of consultant surgeons and anaesthetists not wanting to take on additional operating lists to clear waiting lists. This was because the additional sessions affected consultant pensions, which was a national issue. This risk was on the divisional risk
register for surgery and outpatients. This issue accounted for the increase in locum and agency hours for medical staff during the inspection reporting period.

Trust level

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust’s targets, where applicable. Figures for medical staff are the same at both the trust and Queen Alexandra Hospital, therefore only the trust-level figures are presented below.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>1,413.8</td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td>8,997 (18%)</td>
<td>17,347 (35%)</td>
<td>23,733 (47%)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>324.3</td>
<td>6%</td>
<td>9%</td>
<td>0.8%</td>
<td>14,469 (34%)</td>
<td>330.1</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank use.

Following the inspection, the trust provided updated data for medical staff, which showed that for the period November 2018 to October 2019 no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank and agency use.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
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<td>Target All staff</td>
<td>1,425.5</td>
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<td>3.5%</td>
<td>14,469 (34%)</td>
<td>330.1</td>
<td>7%</td>
</tr>
<tr>
<td>Medical staff</td>
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<td>7%</td>
<td>8%</td>
<td>0.8%</td>
<td>330.1</td>
<td>7%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

* Please note that sickness data was provided for the time period October 2018 to September 2019
Agency staff usage

Monthly agency hours over the last 12 months for medical staff shows a shift from December 2018 to May 2019.
(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Staffing skill mix

In April 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same as the England average.

Staffing skill mix for the whole time equivalent staff working at Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>59%</td>
<td>50%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>22%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Records

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

We reviewed nine sets of patient records and saw an acceptable standard of record keeping. Staff had signed and dated all entries in line with Nursing and Midwifery Council and General Medical Council standards. However, there were different places for recording observations, including on the mobile software information system and on charts in the paper ‘bedside’ notes and care plans. This created a risk staff might need to look in more than one place to access the information they needed. In some cases, staff recorded the same information in more than one place—both electronically and on paper—which was time-consuming. Senior leaders were aware of this risk, and there was a project team working to switch to electronic records across the division.

On the wards, staff stored patients’ clinical notes in lockable filing cabinets opposite the nursing stations. The filing cabinets were unlocked during our visit. However, they were clearly visible from the nursing stations and therefore not left unattended. Staff told us they locked the notes cabinets at night when there were fewer staff and no ward clerks on the ward. On the Surgical Assessment Unit, staff told us they were unable to lock the notes cabinets at night as they did not have keys. However, the ward manager confirmed the service had ordered keys to allow them to lock the cabinets. Whilst waiting for the keys to arrive, the hospital’s information governance team had visited and risk-assessed the current storage situation. They had felt no additional measures were needed in the interim as the risk was low.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff stored and managed medicines and prescribing documents in line with the trust’s policy. Medicines (including controlled drugs) were stored securely. Controlled drugs are medicines liable for misuse that are controlled under the Misuse of Drugs legislation. Two registered nurses checked the stock level of controlled drugs daily. We reviewed controlled drug storage on ward E2.
and saw documentation of daily checks with no gaps. We checked one randomly selected controlled drug and saw the quantity stored in the controlled drugs cupboard matched the quantity recorded in the controlled drugs book.

The service stored refrigerated medicines at the correct temperatures to remain effective. Staff checked and recorded fridge temperatures daily. We reviewed refrigerated medicines on wards D1 and E2 and saw completed fridge temperature monitoring records, with no gaps in daily checks. There was clear guidance for staff to escalate any temperatures out-of-range. We saw staff escalated in line with the policy when needed.

We reviewed nine prescription charts and saw patient information and allergy statuses recorded to ensure safe prescribing. Staff signed and dated prescription charts to document they had given medicines as prescribed. Where applicable, staff prescribed antibiotics in line with trust policy and national guidance.

On the wards, medicine trolleys were locked and secured to walls. During a medicines round on Ward D1, we saw an open medicine trolley left unattended for approximately one minute. We informed the nurse-in-charge, who confirmed that open medicine trolleys should not be left unattended in line with trust policy. The nurse-in-charge told us they would feedback to the nurse involved. We observed another medicine round on ward E2 and saw staff did not leave the open trolley unattended at any time in line with trust policy.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where applicable. We reviewed five root cause analysis investigations following serious incidents. We saw evidence of thorough investigation and patient and family involvement. The investigations identified the root causes of serious incidents and made recommendations for learning. Each root cause analysis report had an action plan, with clear timelines and accountability for the completion of actions to implement and share learning.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. 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. Conversations with medical staff and evidence from root cause analysis reports showed the service applied the Duty of Candour correctly.

Staff received feedback from investigation of incidents and could describe learning and changes to practice following incidents. One example of this was the introduction of a checklist sticker for the notes of any patient given Naloxone (a medicine that blocks or reverses the side effects of opioid (morphine) painkillers, including extreme drowsiness and slowed breathing). The checklist sticker prompted staff to complete all relevant assessments, including renal (kidney) function and respiratory condition before administering Naloxone. The trust subsequently rolled out the
checklist sticker across the other directorates, sharing the learning. Another example of learning from a falls incident was a reminder to nursing staff to complete daily standing and lying blood pressure observations for patients identified at risk of falls in line with trust policy.

**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 August 2018 to July 2019, the trust reported two never events for surgery.

The first event occurred in March 2019. The scaphoid bone was excised instead of the trapezium bone. The scaphoid bone is one of eight bones in the wrist – this was surgically removed in error when it should have been a different bone within the hand (the bone adjacent to the one that was removed in error).

The second event occurred in April 2019. The lateral rectus was resected 5mm rather than being recessed 5 mm. The lateral rectus is a muscle in the eye that allows the eyeball to move to the side. A resection is where the muscle is attached in a different location. However, the muscle was meant to have been recessed, or moved backwards.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with staff. We reviewed the root cause analysis investigation for one of the never events within the reporting period. We saw evidence of a thorough investigation and patient involvement. The investigation identified the root causes of the incident and made recommendations for learning. We saw staff had implemented learning following both never events during our visit to theatres. This included a ‘stop’ moment immediately before the surgeon began operating to confirm the correct site, side or measurement. We saw improved compliance with the World Health Organisation “Five Steps to Safer Surgery” checklist following learning from never events.

**Breakdown of serious incidents reported to STEIS**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported 29 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2018 to July 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>7</td>
<td>24.1%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>6</td>
<td>20.7%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>6</td>
<td>20.7%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>5</td>
<td>17.2%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>2</td>
<td>6.9%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>2</td>
<td>6.9%</td>
</tr>
</tbody>
</table>
Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see. Staff used the safety thermometer data to further improve services. For example, the service held a ‘swarm’ following a patient fall with harm. A swarm is a form of safety incident huddle that takes place as close as possible in time and place to the incident and allows blame-free investigation and prompt action. The divisional governance lead and a falls nurse attended swarms, along with ward staff. A ward manager we spoke with felt swarms were positive in sharing learning to help further reduce falls.

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 13 new pressure ulcers, 10 falls with harm and six new catheter urinary tract infections from May 2018 to May 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>3.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pending review</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>before incident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>is closed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))
**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This included the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons (RCS). For example, staff monitored patients’ temperatures in theatres in line with NICE Clinical Guideline CG65- Hypothermia: prevention and management in adults having surgery.

Staff monitored patients following surgery in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration. We reviewed nine patient records, which all showed evidence of regular observations, for example, blood pressure and oxygen saturation, in line with the guidance.

The service audited staff compliance with trust policies and national guidance. This included monthly audits on the World Health Organisation (WHO) Surgical Safety Checklist. Audits provided assurances around adherence to the safety checklist and helped identify areas for improvement.

Staff accessed policies and standard operating procedures electronically through the trust intranet and knew how to do this. Policies we reviewed had version numbers and review dates, however, we saw some competency and risk assessment forms for completion by staff did not contain review dates. For example, “A Patient Transfer Tool to Evaluate the Level of Risk for Inpatient Moves” did not have a version number or review date. We also saw competency statements for “Manoeuvring an Inpatient or Patient with Spinal Injury” and “Bowel Care for Neurogenic Dysfunction” without updated review dates or version numbers. A matron told us the service recently updated these documents to reflect learning from national alerts. The competency statements were dated 19 June 2007. The matron told us this was the date the service introduced the first version of the competency statements. Not documenting the review dates or version numbers on forms created a risk staff might not know whether they were using the most up-to-date version.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed nine sets of patient notes and saw staff had assessed nutritional status for all patients using the Malnutrition Universal Screening Tool.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. For a patient receiving total parenteral nutrition, we saw an up-to-date, completed chart to monitor the feed, which staff had signed and dated. Total parenteral nutrition is a special feeding technique to provide nutrients through a drip into a vein for patients unable to take food or fluids by mouth.

The trust used a recognised international scale to allow consistent production and easy testing of thickened liquids and texture-modified foods for patients with swallowing difficulties. Staff on the wards had completed taste tests of texture-modified foods. This allowed them to report with confidence to patients that texture-modified foods tasted like the non-modified versions.

The trust provided menus to meet different nutritional and cultural needs, including diabetics, vegetarian and halal. We saw a nurse on the Surgical High Care Unit helping a patient choose a suitable meal from the menu, as they were on a low-fibre diet following colorectal (bowel) surgery. Patients told us they received enough to eat and drink, and we observed regular drinks rounds on the wards.

Dietitians and speech and language therapists provided specialist support for patients who needed it. Dietitians were available on the wards seven days a week. During our visit, we observed a “trolley dash” led by the nutrition team as part of national nutrition week. Dietitians visited the ward with a trolley containing educational resources on nutrition. The trolley dash aimed to help promote nutrition, seek feedback, and provide staff with education and support.

Staff completed patients’ fluid charts where needed. We reviewed four patients’ fluid balance charts and saw nursing staff documented fluid input and output. However, staff had not completed the total daily input and output or calculated the balance of fluids in versus fluids out over a 24-hour period in three out of four charts. This meant it was difficult for colleagues reviewing the chart to see a patient’s fluid balance at a glance.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. We reviewed nine sets of patient records and saw regular pain assessments recorded on the mobile software information system. Nurses asked patients about their pain levels during intentional rounding. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.
Patients we spoke with told us they received pain relief soon after requesting it. We saw staff responding promptly when a patient experienced a sudden increase in pain on the Surgical Assessment Unit.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes, such as anaesthesia clinical services accreditation.

The service participated in relevant national clinical audits. Outcomes for patients were generally consistent with results nationally, and mostly met expectations such as national standards.

**Relative risk of readmission**

*Queen Alexandra Hospital*

From February 2018 to January 2019, patients at Queen Alexandra Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions**

- Upper gastrointestinal surgery patients had a higher than expected risk of readmission for elective admissions
- Ophthalmology patients had a lower than expected risk of readmission for elective admissions
- Urology patients had a higher than expected risk of readmission for elective admissions

**Elective Admissions - Queen Alexandra Hospital**

![Graph showing relative risk of readmission for elective admissions at Queen Alexandra Hospital]

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

**Non-Elective Admissions**

- Colorectal surgery patients had a higher than expected risk of readmission for non-elective admissions
- General surgery patients had a higher than expected risk of readmission for non-elective admissions
- Upper gastrointestinal surgery patients had a higher than expected risk of readmission for non-elective admissions

**Non-elective admissions - Queen Alexandra Hospital**

![Graph showing relative risk of readmission for non-elective admissions at Queen Alexandra Hospital]
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

National Hip Fracture Database

Queen Alexandra Hospital

The table below summarises Queen Alexandra Hospital’s performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means that the trust’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit indicators)</th>
<th>Hospital performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>100.4%</td>
<td>Similar</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of patients having surgery on the day or day after admission (It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</td>
<td>78.6%</td>
<td>Similar</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude peri-operative medical assessment rate (NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</td>
<td>99.2%</td>
<td>Better</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients documented as not developing a pressure ulcer (Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient’s admission); this measures an organisation’s ability to report ‘documented as no pressure ulcer’ for a patient</td>
<td>99.5%</td>
<td>Better</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude overall hospital length of stay (A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay)</td>
<td>19.4 days</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
Metrics (Audit indicators) | Hospital performance | Comparison to other Trusts | Met national standard?
---|---|---|---
may be indicative of a premature discharge and a risk of readmission | | | 
Risk-adjusted 30-day mortality rate
(Adjusted scores take into account the differences in the case-mix of patients treated) | 5.0% | Better than expected | No current standard

(Source: National Hip Fracture Database)

Bowel Cancer Audit

The table below summarises Portsmouth Hospitals NHS Trust performance in the 2018 National Bowel Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
</table>
| Case ascertainment
(Proportion of eligible cases included in the audit) | 106.6% | Good | Good is over 80% |
| Risk-adjusted post-operative length of stay >5 days after major resection
(A prolonged length of stay can pose risks to patients) | 63.4% | Better than national aggregate | No current standard |
| Risk-adjusted 90-day post-operative mortality rate
(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure) | 3.7% | Within expected range | No current standard |
| Risk-adjusted 2-year post-operative mortality rate
(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy) | 21.0% | Within expected range | No current standard |
| Risk-adjusted 30-day unplanned readmission rate
(A potential risk for early/inappropriate discharge is the need for unplanned readmission) | 8.7% | Within expected range | No current standard |
| Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection
(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date) | 44.5% | Better than expected | No current standard |
National Oesophago-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises Portsmouth Hospitals NHS Trust performance in the 2018 National Oesophago-gastric Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment</td>
<td>71 to 80%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Age and sex adjusted proportion of patients diagnosed after an emergency admission</td>
<td>6.4%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality rate</td>
<td>5.6%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Cancer Alliance level metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of patients treated with curative intent in the Cancer Alliance</td>
<td>42.6%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Oesophago-Gastric Cancer Audit)

National Emergency Laparotomy Audit

Queen Alexandra Hospital

The table below summarises Queen Alexandra Hospital’s performance in the December 2016 – November 2017 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).

(Source: National Bowel Cancer Audit)
<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>78%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death</td>
<td>74%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of cases with access to theatres within clinically appropriate time frames</td>
<td>78%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Proportion of patients who were operated on within recommended times)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre</td>
<td>75%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively</td>
<td>78%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 30-day mortality rate</td>
<td>9%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Emergency Laparotomy Audit)

The trust had an action plan to improve their performance in the National Emergency Laparotomy Audit and provided regular updates at quality meetings. The most recent presentation in August 2019 showed improvements with some measures, such as the proportion of patients with a high risk of death (5% or more) who had a consultant surgeon and anaesthetist present at the time of their operation. This improved to 86% (18 out of 21 cases) in the period April to June 2019. The service recognised the areas they still needed to improve and worked to address this, such as by ensuring that colleagues in the intensive care unit assessed and accepted patients from theatre in a timely way.

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>100.0%</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted posterior capsule rupture rate (Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.)</td>
<td>0.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted visual acuity loss (The most important outcome following cataract surgery is the clarity of vision)</td>
<td>0.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Ophthalmology Database Audit)

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

The table below summarises Queen Alexandra Hospital’s performance in the 2018 National Joint Registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (hips, knees, ankles and elbows) (Proportion of eligible cases within the trust that were submitted to the audit)</td>
<td>75.2%</td>
<td>Worse</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) (Patient details help ‘track and trace’ prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)</td>
<td>100.0%</td>
<td>Better</td>
<td>Met</td>
</tr>
<tr>
<td>Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who need their hip replacement ‘re-doing’)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.2</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>
### Hospital level: Knees

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted 5 year revision ratio (for knees excluding tumours)</td>
<td>1.1</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of patients who need their knee replacement ‘re-doing’)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of patients who die within 90 days of their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Joint Registry)

During our inspection, surgical staff felt that the proportion of eligible cases submitted to the audit was better than the 75.2% quoted in the table above. Staff felt that the 75.2% figure was due to coding issues based on uncemented implants. However, the trust used cemented and hybrid implants. The trust provided evidence from their latest (16th) annual report with data from January to December 2018 submitted to the national joint registry, which was published in September 2019. This showed an improved compliance rate of 86%.

### National Prostate Cancer Audit

The table below summarises Portsmouth Hospitals NHS Trust performance in the 2018 National Prostate Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men with complete information to determine disease status</td>
<td>97.6%</td>
<td>N/A</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy</td>
<td>5.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy</td>
<td>4.1%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Complications following surgery may reflect the quality of surgical care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe gastrointestinal complication</td>
<td>10.9%</td>
<td>Within expected</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
Metrics (Audit measures) | Hospital performance | Comparison to other trusts | Met national standard?
--- | --- | --- | ---
requiring an intervention following external beam radiotherapy *(External beam radiotherapy uses high-energy beams to destroy cancer cells)* | range | 

(Source: National Prostate Cancer Audit)

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. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.
In 2016/17 performance on groin hernias was better than the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was about the same as the England average.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. Managers made sure staff received any specialist training for their role. Clinical educators supported the learning and development needs of staff. We reviewed five staff competency folders on ward D4, which showed staff completed a competency package relevant to their role. The service recorded some staff competencies on an electronic system and some in their paper competency folders. Managers monitored the training system to obtain assurances around staff training. We also saw certificates providing evidence of continuing professional development.

Managers made sure staff received any specialist training for their role. For example, staff working on ward D1 (spinal) completed specialist spinal training and competency assessments. These included competencies for moving and handling of patients with spinal injuries and bowel care for patients with neurogenic (nerve) dysfunction. In theatres, we saw thorough competency packages for operating department practitioners and healthcare support workers relevant to their specific roles. All new theatre staff had an allocated ‘buddy’ mentor to support with their induction. The wards ran local teaching programmes relevant to their specialty. We saw a weekly teaching programme for ward D8 (ear, nose and throat), with sessions led by different members of the multidisciplinary team.

Staff attended multidisciplinary simulation training to help them learn to respond to different emergency and non-emergency clinical situations. The hospital’s simulation centre provided a dedicated training environment with scenario-based learning from a variety of clinical settings. We observed the members of the theatre team attending a simulation session with actors. The session
we observed included scenarios of an elderly patient refusing to take their medication, and a young mother with a head injury who wanted to discharge herself from hospital. Staff on ward D8 described the multidisciplinary emergency airways simulation training they attended. Staff feedback on simulation training was positive, and staff told us their managers supported them to attend.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. Although appraisal rates did not meet the trust target of 85%, staff described appraisals as thorough and meaningful.

**Trust level**

From June 2018 to May 2019, 81.1% of required staff in surgery received an appraisal compared to the trust target of 85%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2018 to May 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>296</td>
<td>305</td>
<td>97.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>103</td>
<td>123</td>
<td>83.7%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>281</td>
<td>356</td>
<td>78.9%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>350</td>
<td>461</td>
<td>75.9%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>135</td>
<td>191</td>
<td>70.7%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1175</td>
<td>1448</td>
<td>81.1%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

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

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. We observed positive multidisciplinary working throughout our visit, and staff spoke of positive relationships between different staff groups. All patient records we reviewed demonstrated input into patients’ care from a variety of different professional groups. These included doctors, nurses, dietitians, physiotherapists, occupational therapists and mental health professions, where relevant. Records showed staff involved family members in patient’s care where relevant. We also observed staff involving relatives in care planning, including a family meeting with the patient and staff members.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service also worked well with neighbouring trusts to deliver speciality care. The spinal service worked closely with a local tertiary centre through consultants and a trauma coordinator. A consultant surgeon from the trust attended weekly multidisciplinary meetings at the tertiary centre.
Staff gave patients relevant information before discharge and worked with other agencies where relevant to discharge patients. Discharge planning was multidisciplinary and included input from physiotherapists and occupational therapists on patients’ suitability for discharge. We observed a discharge on ward E2, and saw the nurse provided the patient with thorough information. This included information around pain relief, wound care, transport and activities to avoid post-surgery. The nurse gave the patient the opportunity to ask any questions.

Nursing staff in the discharge lounge received telephone handovers from ward staff. Staff completed a checklist to ensure patients had everything they needed before discharge. This included transport, medicines to take home, clothes and a copy of their discharge summary. The service shared discharge summaries with patient’s GPs and other healthcare professionals to facilitate ongoing care. The checklist also ensured relevant patients had an ongoing package of care arranged and a copy of their “do not attempt cardiopulmonary resuscitation” order if applicable.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards, including weekends. We saw evidence of daily medical review in all patient notes we reviewed.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The hospital’s mental health liaison service was open 24 hours a day, seven days a week. Staff knew how to contact the team if they had any concerns about a patient’s mental health, including how to escalate an urgent referral.

The trust’s magnetic resonance imaging (MRI) facilities were not open 24 hours a day. However, the trust had a service-level agreement to transfer any inpatients needing an urgent MRI scan between the hours of 8pm and 8am when the hospital’s MRI service was closed.

Physiotherapists and occupational therapists provided cover on the wards seven days a week. Speech and language therapists provided on-site cover five days a week, Monday to Friday. However, the service had nursing staff with training to complete any urgent patient swallowing assessments for patients that needed one out-of-hours.

### Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

Staff assessed each patient’s health and provided support for any individual needs to live a healthier lifestyle. The service ran a multidisciplinary ‘surgery school’ with surgeons, physiotherapists and a perioperative lead. Surgery school helped patients adopt healthier lifestyle habits and increase their fitness levels before surgery. The service invited all patients planning major bowel, gynaecology and urology surgery to attend, and 85% of patients accepted the invitation. Feedback showed 90% of patients who attended changed their lifestyles, and 100% said they would recommend it to other patients. One patient who attended surgery school spoke at a trust board meeting to give positive feedback about how much the initiative had benefitted them.

The service had relevant information promoting healthy lifestyles and support on the wards. These included local smoking and alcohol cessation services, and weight loss services. We also saw leaflets providing practical advice for patients and carers on falls and pressure ulcer prevention.
The wards had display boards educating patients on improving their health, such as the importance of drinking enough water. We also saw a nurse and therapist discussing the option of a nicotine replacement patch with the patient as an alternative to smoking cigarettes.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in patients’ records. We reviewed 11 consent forms and saw staff obtained consent for surgery in line with Royal College of Surgeons’ guidance.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients lacked capacity to give consent, staff made decisions in their best interest. Medical staff documented best interest decisions and completed a consent form for adults who lack the capacity to consent to investigation or treatment. They involved family members in discussions when making best interests’ decisions in line with best practice.

The service monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. This was an improvement from our previous inspection in April 2018, when we saw poor completion of Deprivation of Liberty Safeguards paperwork and mental capacity assessments. We saw folders on the wards with a log of all patients on the ward with a Deprivation of Liberty Safeguards order and the date of expiry. Local safeguarding leads reviewed the notes of all patients with a Deprivation of Liberty Safeguards order every week. They supported staff on the wards in making Deprivation of Liberty Safeguards applications if needed.

We reviewed the notes for five patients with a current Deprivation of Liberty Safeguards order. We saw staff had completed mental capacity assessments for all five patients. They had fully completed Deprivation of Liberty Safeguards paperwork and sent applications to the local safeguarding authority in line with national legislation. Patient records showed evidence of weekly review where patients stayed in hospital for longer than seven days. This included a review as to whether the current Deprivation of Liberty Safeguards order was still suitable for the patient as the least restrictive option.

Medical staff correctly completed ‘do not attempt cardio-pulmonary resuscitation’ forms where applicable in line with Resuscitation Council (UK) guidance. We reviewed three completed ‘do not attempt cardio-pulmonary resuscitation’ forms and saw these were completed and signed in line with national guidance and legislation. This was an improvement from our previous inspection in April 2018, where we found poor completion of ‘do not attempt cardio-pulmonary resuscitation’ forms.

**Mental Capacity Act and Deprivation of Liberty training completion**

**Trust level**
The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. Figures for qualified nursing staff are the same at both the trust and Queen Alexandra Hospital, therefore only the trust-level figures are presented below.

A breakdown of compliance for MCA/DOLS training modules from 1 April 2019 to 21 July 2019 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>463</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>412</td>
</tr>
</tbody>
</table>

In surgery the target was met for two of the two MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DOLS training modules from 1 April 2019 to 21 July 2019 at trust level for medical staff in surgery is shown below. Figures for medical are the same at both the trust and Queen Alexandra Hospital, therefore only the trust-level figures are presented below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>261</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>212</td>
</tr>
</tbody>
</table>

In surgery the target was met for one of the two MCA/DOLS training modules for which medical staff were eligible.

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients said staff treated them well and with kindness. Patients we spoke with gave positive feedback about the care they received from staff, despite staff often being “busy”. Patients described staff as “friendly”, “cheery” and “brilliant”. One patient said the nurses caring for them were “like angels”. We also saw positive feedback in thank you cards from patients and relatives displayed on the wards. Comments included, “We were so impressed with the care and comfort you gave her”, and “Thank you for the kindness and respect you showed to [patient] and our family. This has made this difficult time easier to bear”.

Staff understood and respected the personal, cultural, social and religious needs of patients. On Ward D4, the senior sister ran an annual Christmas appeal and collection donations of Christmas gifts from people in the local area. Staff wrapped the gifts, put on Christmas hats and delivered them to the patients on Christmas morning. Last year, the ward received over 300 gift donations.
Staff saved any leftover gifts and gave them to patients on their birthdays. They also described an occasion when they decorated a young patient’s room with balloons and helped them celebrate their birthday.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We reviewed a comment on the hospital’s ‘wonder wall’ relating to care from staff towards a patient with mental health needs and a learning disability. It said, “I took a lady with challenging behaviours to the eye department for a pre-operative appointment yesterday. The staff were fantastic. They made the whole experience lovely, positive and they are incredibly supportive and caring. This made a huge difference to the visit and to this patient”.

Staff respected patients’ privacy and dignity. We saw staff closing curtains to respect patients’ privacy and dignity when delivering care or having conversations. In theatres, staff maintained patients’ dignity by keeping them covered. Immediately after a patient fell on ward E3, we saw staff cordon off the area with screens so they could maintain the patient’s privacy and dignity while they assisted them back to bed.

**Friends and Family test performance**

The Friends and Family Test response rate for surgery at Portsmouth Hospitals NHS Trust was 38% from June 2018 to May 2019.

A breakdown of response rate by site can be viewed below.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp1,2</th>
<th>Resp. Rate</th>
<th>Percentage recommendeda</th>
<th>Annual perf1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td>5,559</td>
<td>38%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Cophthalmolog</td>
<td>2,791</td>
<td>31%</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward E1</td>
<td>1,048</td>
<td>39%</td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td>Ward D5</td>
<td>982</td>
<td>46%</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward D6</td>
<td>873</td>
<td>35%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward E3</td>
<td>624</td>
<td>45%</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>Ward E2</td>
<td>553</td>
<td>38%</td>
<td>89%</td>
<td>98%</td>
</tr>
<tr>
<td>D7</td>
<td>422</td>
<td>32%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward D1</td>
<td>345</td>
<td>59%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward D6</td>
<td>288</td>
<td>68%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward E4</td>
<td>142</td>
<td>22%</td>
<td>96%</td>
<td>91%</td>
</tr>
<tr>
<td>Surgical High</td>
<td>110</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

4. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.
5. Sorted by total response.
6. 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.

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff in theatres reassured and comforted patients before surgery and afterwards in recovery.
We observed staff on ward E3 comforting and reassuring a patient who was feeling shocked and embarrassed following a fall.

Staff supported patients who became distressed. We observed a patient on ward D1 who became agitated and was swearing at staff. A ward clerk spoke with the patient, offered them a cup of coffee and helped lower his anxiety. The patient calmed down and returned to their bed space.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing. On ward D4, staff told us about a patient who often became bored. They described how nursing staff took him for walks and allowed him to help the ward clerk put together admission pack leaflets. They understood the patient’s need for a sense of purpose and took action to meet this.

The hospital’s chaplaincy team provided spiritual and emotional support for patients and relatives of all faiths, including those with no faith. The chaplains were available 24 hours a day, seven days a week for urgent referrals.

**Understanding and involvement of patients and those close to them**

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff giving patients the opportunity to ask any questions during conversations. We observed a physiotherapist on ward E2 giving thorough explanations of individual exercises and why they were important. They provided reassurance and encouragement throughout the process.

The service actively involved patients’ relatives as partners in their care. Patient records we reviewed demonstrated family involvement in discussions about care where applicable. We observed a family meeting on ward D1 between staff, a patient and their relative to discuss discharge plans. The service provided specific ‘carers cups’ so carers could receive free cups of tea or coffee at the same time as patients. This allowed relatives to spend more time at the bedside with patients.

The service encouraged patients to wear daytime clothes rather than pyjamas to help them feel more like themselves. This can have a positive effect on patient’s health and wellbeing. The hospital had implemented the national #EndPJparalysis campaign, and we saw information posters and leaflets for patients and relatives on the wards. Staff encouraged relatives to bring in clean clothes for patients. On ward D4, staff described a patient who had no family living nearby to bring in clothes. Nursing staff on the ward took turns taking the patient’s washing home so he had his own clothes to wear. The patient also wanted his hair cut, and a member of nursing staff gave him a haircut to help him feel more like himself.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served.
The service worked with others in the wider system and local organisations to plan care. Ear, nose and throat consultants ran clinics for patients at another local trust. This allowed patients having surgery at the trust to have their pre-operative consultations and follow-up appointments closer to home. The spinal service worked closely with a local tertiary centre through consultants and a trauma coordinator.

Staff supported patients when they were referred or transferred between services, such as the nearby tertiary centre. On ward D4 (trauma), nursing staff described how they met with patients in the intensive care unit before they transferred to the ward. This helped patients prepare for the transition to the ward.

The service relieved pressure on other departments where possible. Nursing staff on ward D8 (ear, nose and throat) described occasions when they attended the emergency department to review patients and start their treatment when the emergency department was busy. The Surgical Assessment Unit also helped reduce pressure on the emergency department.

Facilities and premises were suitable for the services being delivered. However, the Surgical High Care Unit lacked patient toilet facilities. To mitigate this risk, staff escorted patients able to walk to the toilet on the adjacent ward E4 and provided bedside commodes for patients unable to walk to the toilet. Staff explained that many patients staying in the Surgical High Care Unit had stomas and catheters and therefore did not need to use a toilet.

### Meeting people’s individual needs

**The service was inclusive and took account of patients’ individual needs and preferences.**

Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw dementia activity trolleys on the wards. These included items such as ‘twiddlemuffs’ (knitted hand muffs that contain zips, buttons and other items to occupy hands), jigsaw puzzles and music CDs from the time of the second world war. These items helped occupy patients living with dementia and lessen any anxiety. The service had implemented the national ‘John’s Campaign’. This allowed carers and relatives of patients living with dementia to visit at any time of the day, including outside of normal visiting times.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents. This allowed staff to learn about and meet patients’ individual needs and preferences. The service used the ‘forget-me-not’ flower magnets as a discrete means of identifying patients living with dementia for additional support. On ward D8, a nurse described how they invited patient’s relatives to support them during minor ear, nose or throat procedures if the patient had a learning disability or was living with dementia. Patients with learning disabilities were able to visit the ward before their procedure to familiarise themselves with the staff and environment. Staff told us they supported carers of patients with learning disabilities to stay overnight on the ward if they wanted to and provided them with food and drink.

Staff met the communication needs of patients with a disability or sensory loss. They had access to communication aids to help patients become partners in their care and treatment. We saw communication picture aids on ward D8, which staff used to help patients with difficulty...
communicating. Staff also described how they used pens and paper for patients who struggled to verbalise their needs, such as following throat surgery.

Managers made sure staff, and patients, relatives and carers could get help from interpreters when needed. Staff we spoke with knew how to book interpreters for patients who needed them. They understood the importance of using a professional interpreter and not using family members or friends to interpret for patients. On ward D8, we saw a list of common phrases in different languages spoken by the local population, so patients could communicate basic needs to staff.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were generally in line with national averages.

Managers and staff worked to make sure that they started discharge planning as early as possible. This started at pre-assessment for patients having elective operations. Pre-assessment staff discussed transport and help at home with patients, so the service could start planning any additional support the patient might need following surgery.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had a ‘virtual ward’, called “QA at home”, for trauma and orthopaedic patients. This initiative had 35 places. Patients stayed under their consultant’s care and continued their care at home, with home visits from nursing, physiotherapy and occupational therapy staff. Staff we spoke with told us this initiative was popular with patients, as it allowed them to continue their recovery in their own environment.

**Average length of stay**

**Queen Alexandra Hospital**

From March 2018 to February 2019, the average length of stay for surgical elective patients at Queen Alexandra Hospital was 3.8 days, which is similar to the England average of 3.8 days. For surgical non-elective patients, the average length of stay was 5.0 days, which is higher than the England average of 4.7 days.

**Elective Average Length of Stay**

- Average length of stay for patients having elective trauma and orthopaedics surgery at Queen Alexandra Hospital was 4.0 days. The average for England was 3.7 days.
- Average length of stay for patients having elective ear, nose and throat (ENT) surgery at Queen Alexandra Hospital was 2.4 days. The average for England was 2.1 days.
- Average length of stay for patients having elective upper gastrointestinal surgery at Queen Alexandra Hospital was 4.2 days. The average for England was 4.4 days.
Elective Average Length of Stay - Queen Alexandra Hospital

Note: Top three specialties for specific site based on count of activity.

Queen Alexandra Hospital - non-elective patients

- Average length of stay for patients having non-elective trauma and orthopaedics surgery at Queen Alexandra Hospital was 11.0 days. The average for England was 8.4 days.
- Average length of stay for patients having non-elective colorectal surgery at Queen Alexandra Hospital was 3.8 days. The average for England was 4.2 days.
- Average length of stay for patients having non-elective upper gastrointestinal surgery at Queen Alexandra Hospital was 3.0 days. The average for England was 3.9 days.

Non-Elective Average Length of Stay - Queen Alexandra Hospital

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From June 2018 to May 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently about the same as the England average

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>81.8%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>78.2%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>64.2%</td>
<td>56.1%</td>
</tr>
</tbody>
</table>

Four specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>72.9%</td>
<td>79.2%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>67.6%</td>
<td>72.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>66.3%</td>
<td>75.3%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>42.4%</td>
<td>58.6%</td>
</tr>
</tbody>
</table>

The Surgery and Outpatients division held weekly waiting list management meetings at care group and divisional level. Senior leaders we spoke with described a high level of internal scrutiny around waiting lists and knew which patients had been waiting the longest. The service had experienced some issues with consultants not wishing to take on additional operating sessions to help clear waiting lists. This risk was on the divisional risk register and related to national issues with consultant pensions. However, theatres recently had an external “four eyes” visit to help generate ideas to improve theatre utilisation and productivity. The report was not yet available at the time of our visit. However, managers hoped it would help the service increase the number of theatre slots to improve waiting lists for some specialties.

Cancelled operations

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

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.

Overall, over the two-year period, April 2017 to March 2019, the percentage of cancelled operations at the trust where the patient was not treated within 28 days was better than the England average. There was one quarter in which the percentage of cancellations was higher than the England average, which was Q1 2018/19 (April to June 2018) where percentage of cancellations rose from 7% to 16%.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Portsmouth Hospitals NHS Trust
Over the two years, the percentage of cancelled operations at the trust was generally similar the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Patient moving wards per admission

From June 2018 to May 2019 all surgical patients moved wards at least once during their admission. Additionally, 2.5% of patients moved wards twice or more during the same period.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From June 2018 to May 2019, there were 304 patients who moved wards at night within surgery.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

The service moved patients only when there was a clear medical need for a bed or in the patient’s best interest. The service used a risk assessment tool to assess the risk of ward moves for individual patients. Staff described how they avoided moving vulnerable or confused patients, such as those living with dementia.
Learning from complaints and concerns
It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

The service clearly displayed information about how to raise a concern in patient areas. We saw leaflets on wards we visited providing patients and relatives with information about how to make a complaint.

Managers shared learning from complaints and concerns with staff to improve the service. Staff we spoke with were able to give examples of changes to practice following complaints. This included introducing hard copies of neuro-observation charts as part of patients’ bedside notes following an injury or bump to the head. We saw laminated reminders to complete neuro-observations where relevant attached to monitors.

The service responded to patient feedback to continually improve patient experience. The wards had patient experience “you told us…we listened and did” boards, which gave details of how the service had responded to patient feedback. For example, on ward D8 patients and relatives fed back that they preferred longer visiting hours. The ward subsequently extended visiting hours to the new times of 8am to 8pm in response. On the Surgical Assessment Unit, patients and relatives requested more equipment for ensuring interaction. The service responded by providing music, board games and art work.

We saw some evidence of learning in complaint responses we reviewed. However, one out of the five complaint responses we reviewed was lacking in empathy. Complaint responses included a detailed investigation report, with evidence of review and thorough investigation by relevant staff. However, the investigation reports sometimes included clinical language without explanations in plain English, which might have been difficult for some complainants to understand.

Summary of complaints

Trust level

From June 2018 to May 2019 the trust received 96 complaints in relation to surgery at the trust (13.2% of total complaints received by the trust). The trust took an average of 45.5 days to investigate and close complaints. This was not in line with their complaints policy, which states that complaints should be closed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>55</td>
<td>57.3%</td>
</tr>
<tr>
<td>Communication (oral)</td>
<td>8</td>
<td>8.3%</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>6</td>
<td>6.3%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>6</td>
<td>6.3%</td>
</tr>
<tr>
<td>Admissions / transfers / discharge procedure</td>
<td>6</td>
<td>6.3%</td>
</tr>
<tr>
<td>Patient privacy / dignity</td>
<td>3</td>
<td>3.1%</td>
</tr>
<tr>
<td>Date for appointment-delay/cancellation (outpatient)</td>
<td>3</td>
<td>3.1%</td>
</tr>
<tr>
<td>Date of admission / attendance (Inpatient)</td>
<td>2</td>
<td>2.1%</td>
</tr>
<tr>
<td>Access to Treatment</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Aids / appliances / equipment</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Type of complaint</td>
<td>Number of complaints</td>
<td>Percentage of total</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Mortuary / post mortem arrangements</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Test results</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Consent to treatment</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Cleanliness / laundry</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Communication (written)</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total</td>
<td>96</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From June 2018 to May 2019 there were 875 compliments received for surgery at Queen Alexandra Hospital (17.5% of all received trust wide).

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

**Is the service well-led?**

**Leadership**

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

Leaders were visible and approachable in the service for patients and staff. All staff we spoke with said they felt well-supported by their line manager as well as senior leaders. Staff at all levels could identify divisional leaders as well as members of the executive team. They described occasions when senior leaders visited their wards and departments and described them as approachable. Two new managers in theatres received nominations for the trust’s ‘inspirational management’ award for their leadership skills.

The trust invested in senior managers to develop their leadership skills. Two members of the surgical and outpatients’ divisional leadership team completed a bespoke development course aligned to the trust’s three-year culture change programme. This programme helped senior leaders develop a compassionate and inclusive leadership approach to support the delivery of the trust strategy. Senior leaders we spoke with reported this was a valuable and useful programme. New members of the divisional leadership team who had not had the opportunity to attend planned to join the next intake for the programme.

Leaders supported staff to develop their skills and take on more senior roles. On the trauma and orthopaedic wards, the matron encouraged band five staff nurses wanting to develop into band six sister roles to lead shifts with the support and oversight of their managers. This helped them develop the competencies they needed to progress into band six roles. We spoke with a band five nurse aspiring to progress to band six, who said they enjoyed the challenge and felt supported in their development. The trust also ran a ‘passport to manage’ course for aspiring managers. The trust funded a small number of health care support workers in surgery to complete an open university nursing course. We spoke with a health care support worker who was training to be a nurse. They felt supported by the service in having the opportunity to train and progress in their
career and enjoyed working a small number of shifts as a health care support worker alongside their nurse training.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The trust launched the strategy for the surgery and outpatients’ division in July 2019, therefore it was still in its early stages. However, we saw progress with some areas of the strategy, such as with robotic surgery in urology. The divisional strategy linked to the trust’s strategic aims, such as financial sustainability. Divisional leaders held staff briefing sessions after launching the strategy. Local leaders we spoke with, such as matrons, were able to describe elements of the strategy, such as the vision to become a centre of excellence for knee revision surgery. On some wards, we saw posters displaying the divisional strategic aims.

The vision and strategy for the clinical delivery division was also in its infancy following the restructure into the new directorates. We saw the strategy, which was clearly linked to the trust’s strategic aims, included financial sustainability. It had timelines for completion and details of progress. Senior leaders were able to describe some areas of progress against the strategy for theatres, such as an external review to help identify areas to improve theatre utilisation.

Staff could describe how they applied the trust values in their day-to-day work. We saw posters displaying the trust values on noticeboards on the wards. The values were “working together”, “for patients”, “as one team”, “with compassion” and “always improving”.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff said they felt the trust was a good place to work, despite often feeling busy. They described the culture as “friendly”, “supportive” and “like a family”. Staff supported each other across the surgical wards, and nursing staff demonstrated a willingness to help and switch wards if a particular ward was busy. A health care support worker we spoke with said, “we are all one team”.

The service promoted equality and diversity in daily work and provided opportunities for career development. Following a successful recruitment campaign, the trust recruited a large number of overseas nurses. During our visit, we heard numerous examples of staff warmly welcoming overseas nurses and helping them settle, both into the trust and into the local area. Staff told us an example of colleagues showing an overseas nurse around the local area, taking her to the beach and out for dinner to help her feel more settled. Some of the wards had regular evenings out together to help new overseas nurses get to know their colleagues better.

The service had an open culture where patients, their families and staff could raise concerns without fear. We saw posters with details of the trust’s freedom to speak up guardian on the wards, and the guardian had scheduled a visit to theatres in the week of our inspection. In theatres, staff described a more open and learning culture since the appointment of two new managers. They told us staff morale had improved, and one person told us, “it is now a lovely
place to work”. We saw staff felt able to challenge each other, for example, when a colleague did not follow the uniform policy. We saw the safety culture in theatres had improved since our last inspection. Staff now engaged fully with the World Health Organisation “Five Steps to Safer Surgery” checklist to keep patients safer in theatres.

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Since our last inspection in April 2018, the trust restructured 11 clinical service centres into four new clinical divisions. Each division had a clinical (consultant) divisional director, a divisional nurse director, a divisional operations director, a divisional finance director, and a divisional human resources business partner. The new structure had brought in senior leadership for finance and human resources at divisional level. This was to help achieve the trust’s strategic aims relating to financial sustainability and workforce.

Care groups/specialties fed into the new divisions. The surgery core service fitted into two care groups in the surgery and outpatients’ division, and two care groups in the clinical delivery division. The two care groups relating to surgery within the surgery and outpatients’ division were:

- Musculoskeletal/head and neck.
- Surgery

The two care groups within the clinical delivery division, were:

- Critical care, theatres, anaesthetics and hospital sterilisation and disinfection unit.
- Clinical support services. This included therapy, laboratory and pharmacy services for the whole trust.

Staff and senior leaders reported that although the new structure had taken a little while to settle, it was now working well. A matron spoke positively of the new structure and how it had “given more ownership back to the wards”. Care group meetings fed into the monthly divisional governance meetings. We reviewed copies of monthly divisional governance meetings and governance review reports. We saw leaders reviewed quality, safety and performance items including incidents, safeguarding, staff training, audits, complaints and patient satisfaction results to help drive improvement.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. It used a systematic approach to continually improve the quality of the service.

Managers we spoke with at all levels understood the risks to the service and could describe action to reduce risks. For example, the service had identified a risk of consultants wanting to reduce their number of programmed activities (sessions) due to national issues with pensions. They identified this as a risk to both delivery of patient care and to the divisional financial position. The
service was working to reduce this risk by increasing efficiency, such as in theatre utilisation, to free up additional consultant time for operations.

The service had oversight of risks at local, care group and divisional level. Senior leaders regularly reviewed risk registers and updated them with actions taken to reduce risks and any changes in risk ratings. The service held local risk registers for theatres and wards. These fed into care group risk registers, and further upwards into divisional risk registers. The divisional risk registers fed into the trust-level risk register.

The service monitored a range of performance and outcome measures each month. They acted to address performance that fell below targets for example, the number of never events. The service had acted to strengthen leadership in theatres and improve the safety culture following never events.

Theatres had implemented the National Safety Standards for Invasive Procedures (NatSSIPs) within Local Safety Standards for Invasive Procedures (LocSSIPs). NHS Improvement published the National Safety Standards for Invasive Procedures (NatSSIPs) in September 2015 to help NHS organisations provide safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical never events can occur. Staff in theatres followed Local Safety Standards for Invasive Procedures (LocSSIPs) when carrying out the WHO Surgical Safety Checklist. This including following policies for counting needles, swabs and instruments, and checking of implants during surgery.

**Information management**

The service collected reliable data and analysed it to understand performance, make decisions and improvements.

The service shared relevant performance information with staff and patients. We saw relevant information displayed on notice boards within clinical areas. This included safety thermometer data, staffing data and NHS Friends and Family recommendation rates.

The information systems were secure. We saw staff followed information governance principals, such as locking their computer screens when they were away from their desks. There were plans to reduce the reliance on paper records and switch to electronic records by the end of the year. There were also plans to upgrade the trust’s picture archiving and communication system (a system for storing images from patient x-rays and scans) to allow sharing across neighbouring trusts. This would facilitate continuity of care, such as for trauma patients referred to the neighbouring tertiary centre. The clinical delivery division had plans to upgrade the pathology and microbiology reporting systems.

**Engagement**

Leaders and actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Divisional managers engaged well with staff. As a new team, they held drop-in sessions for staff where they could ask questions or discuss concerns. Surgery and outpatients had a divisional social media account where they celebrated achievements and successes. They had an ambition to introduce a divisional newsletter for staff. The divisions monitored staff satisfaction through
quarterly ‘pulse’ surveys. For the surgery and outpatients’ division, the proportion of staff feeling secure in raising concerns about clinical practice had improved from 68% between April to June 2018 to 85% between April to June 2019. The proportion of staff who felt able to make improvements happen in their area of work increased from 55% between April to June 2018 to 66% between January to March 2019.

The trust had various awards to recognise and reward staff excellence. Staff in the hospital sterilisation and disinfection unit received an award for their dedication and commitment in working with offsite sterilisation units to ensure theatres had enough sterile instruments to keep working after a machine broke down. Staff involved in setting up and delivering ‘surgery school’ to help patients lead healthier lives before and after surgery also won an award for this initiative. There were also local awards to recognise individual staff who had recently gone ‘above and beyond’.

The service engaged with patients and invited a patient to attend and provide insight at weekly divisional patient safety meetings. The trust held patient forums and community engagement events. A senior sister on ward D4 engaged with the local community through social media to source Christmas gifts for patients.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service had made improvements in several areas since our previous inspection in April 2018. In particular, we saw improvements in theatre safety culture, leadership and application of the Mental Capacity Act (2005) and Deprivation of Liberty safeguards.

The trust was the first in the UK to provide robot-assisted knee surgery for NHS-funded patients. The service introduced robotics for knee replacement surgery in January 2019. Five patients each week received this procedure. Initial outcome results showed patients were discharged up to 24 hours sooner than with traditional knee replacement surgery. The service also used robot-assisted surgery for urology procedures such as prostatectomy (removal of the prostate). This reduced patients’ need for pain relief, as well as resulting in patients being discharged up to two days earlier than following conventional surgery.

The service was shortlisted for a British Medical Journal award in the category of ‘best anaesthetic and perioperative team of the year’. The nomination was for a project trialling fascia iliaca block (a type of local anaesthetic) to provide pain relief for patients with a fractured neck of femur (hip) in the emergency department and on the surgical wards. The project, led by a junior doctor, was multidisciplinary and included colleagues in pharmacy and the emergency department. The team attended a national awards ceremony.
Maternity

Facts and data about this service

The maternity service at Queen Alexandra Hospital in Portsmouth is consultant led and provides care and treatment for women with high risk pregnancy or medical complications. The trust also offers a home birth service. The Mary Rose unit (B5) is a co-located midwife led unit with two birthing pools offering maternity services to low risk women.

The maternity services provide care and treatment to women living in Portsmouth and the surrounding areas.

The maternity services include hospital and community settings ensuring that women receive care across the antenatal, labour and post-natal periods. The service provides pre-natal diagnostic services such as foetal medicine, ante-natal screening facilities and the ultrasound sonography (USS) service. The trust also has a maternity assessment unit which is midwife led and based at the main site.

The trust has three standalone maternity centres as well as a co-located maternity centre at Queen Alexandra Hospital;
- Blake maternity centre based at Gosport War Memorial Hospital
- Grange maternity centre based in Petersfield Community Hospital
- Portsmouth maternity centre based in St Mary’s Community health campus.
- Ward B5 co-located maternity centre.

The trust has a foetal medicine sub-specialty.

(Source: Trust Provider Information Request – Acute sites)

From January 2018 to December 2018 there were 5,065 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of deliveries at Portsmouth Hospitals NHS Trust – Comparison with other trusts in England
A profile of all deliveries and gestation periods from January 2018 to December 2018 can be seen in the tables below.

At Portsmouth Hospitals NHS trust, data relating to gestation periods was not submitted to HES for 75.5% of deliveries compared to 18.7% nationally during this time period. The trust was aware of this issue and was working to procure a new maternity system to be able to submit a full and complete data set.

<table>
<thead>
<tr>
<th>Profile of all deliveries (January 2018 to December 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Portsmouth Hospitals NHS Trust</strong></td>
</tr>
<tr>
<td>Deliveries (n)</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Multiple</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
</tr>
<tr>
<td>Under 20</td>
</tr>
<tr>
<td>20-34</td>
</tr>
<tr>
<td>35-39</td>
</tr>
<tr>
<td>40+</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
Gestation periods (January 2018 to December 2018)

<table>
<thead>
<tr>
<th>Psychiatry and mental health trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
</tbody>
</table>

**Gestation period**

At Portsmouth Hospitals NHS Trusts, gestation periods were incomplete for 75.5% of deliveries compared to 18.7% nationally from January 2018 to December 2018.

**Total number of deliveries with a valid gestation period recorded**

<table>
<thead>
<tr>
<th>Total</th>
<th>1,240</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>472,862</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods were unrecorded for 75.5% of deliveries at this trust compared to 18.7% nationally.

(Source: Hospital Episode Statistics (HES))

During this inspection we visited the following wards/units across maternity services.

- The maternity assessment unit (MAU), where women requiring advice, review and treatment were triaged.
- Staff were able to perform scans as outpatients thus avoiding admissions and enabling women to return for regular checks as required.
- B8-Labour ward, a 21 bedded unit with a birthing pool.
- B6- Antenatal ward with 16 beds
- B7- Post- natal ward with 31 beds.
- B5 which is the co- located birthing unit with 4 labour rooms, including 2 birthing pools, 4 bedded post- natal bay and 2 triage rooms.,
- A four-bedded induction of labour bay.
- Antenatal outpatient clinic.

The midwives are organised into geographical case loading teams delivering midwifery or obstetric led care. This ensured that the workforce could respond flexibly to the demands of the service.

Uncomplicated pregnancies are midwife-led throughout pregnancy and birth, and the care of women with specific complications are managed by the midwives and the obstetric team using agreed pathways and guidelines.

Outpatient antenatal services consist of antenatal clinics, the maternity assessment unit (MAU), ultrasound and foetal medicine and combined outpatient clinics with diabetes, maternal medicine, perinatal mental health, multiple births clinics, pre-term clinic and complex care clinic.

Community midwives are linked to a Consultant obstetrician. The trust had a continuity of carer team called ‘Athena’

The trust also has midwives who specialise in bereavement, perinatal mental health, diabetes, safeguarding, public health, infant feeding, screening, perineal trauma/ female genital mutilation (FGM), and midwife sonographers.
Our inspection was announced. The inspection team spoke with 18 patients and their relatives, appropriately 20 members of staff including midwives, maternity support workers, consultants, junior doctors, receptionists, allied health professionals and domestic staff. We observed care and treatment and reviewed 16 patients’ records. We reviewed information provided by the trust both before and after the inspection.

**Is the service safe?**

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The trust set a target of 85% for completion of mandatory training.

The trust provided medical staffing data in the routine provider information request under the gynaecology core service. Therefore; we were unable to analyse data specifically for medical staff within the maternity core service.

**Trust level**

A breakdown of compliance for mandatory training courses from 01 April 2019 to 21 July 2019 at trust level for midwives in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>01 April 2019 to 21 July 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>Staff trained: 233</td>
<td>Eligible staff: 233</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>Staff trained: 232</td>
<td>Eligible staff: 233</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>Staff trained: 232</td>
<td>Eligible staff: 233</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>Staff trained: 231</td>
<td>Eligible staff: 233</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>Staff trained: 231</td>
<td>Eligible staff: 233</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>Staff trained: 230</td>
<td>Eligible staff: 233</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>Staff trained: 110</td>
<td>Eligible staff: 117</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>Staff trained: 110</td>
<td>Eligible staff: 126</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>Staff trained: 150</td>
<td>Eligible staff: 172</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Staff trained: 126</td>
<td>Eligible staff: 153</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>Staff trained: 130</td>
<td>Eligible staff: 173</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>Staff trained: 119</td>
<td>Eligible staff: 171</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for nine of the 12 mandatory training modules for which midwives and nursing staff were eligible.

**Queen Alexandra Hospital maternity department**

The service provided mandatory training in key skills to all staff although data for medical staff on mandatory training was not available.
Breakdown of compliance for mandatory training courses from 01 April 2019 to 21 July 2019 for midwives in maternity at Queen Alexandra Hospital is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>145</td>
<td>145</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>145</td>
<td>145</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>145</td>
<td>145</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>144</td>
<td>145</td>
<td>99.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>144</td>
<td>145</td>
<td>99.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>144</td>
<td>145</td>
<td>99.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>91</td>
<td>98</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>89</td>
<td>98</td>
<td>90.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>111</td>
<td>125</td>
<td>88.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>102</td>
<td>125</td>
<td>81.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>100</td>
<td>126</td>
<td>79.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>90</td>
<td>125</td>
<td>72.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity, the 85% target was met for nine of the 12 mandatory training modules for which qualified midwifery and nursing staff at Queen Alexandra Hospital were eligible. The staff were not complaint in some key training such as adult basic life support and blood transfusion.

The trust provided medical staffing data in the routine provider information request under the gynaecology core service. Therefore, we were unable to analyse data specifically for medical staff within the maternity core service.

The medical staff we spoke with said they undertook training as required. The trust could not show how they were sure medical staff had completed the required mandatory training in order to provide safe and effective care.

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

We found staff had completed mandatory training in moving and handling of people. Data showed 90% staff had completed this training. However, we were not assured that staff had completed the necessary training in the emergency evacuation of women and babies from the birthing pool. This presented a risk that staff might not know the best way to respond in an emergency.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

The trust had guidance and policies on safeguarding women and babies which staff felt confident in using, and they knew how to access. The safeguarding policy was updated in October 2019 and was available on the trust’s website.
Midwives and maternity support workers understood their responsibilities of how to protect women and babies from abuse. The maternity service worked closely with the other agencies. The service took a multidisciplinary approach to safeguarding women and babies. They worked well with the trust's safeguarding team, other departments, community services and the local authority safeguarding team. Staff told us any safeguarding concerns which may pose a risk to women and babies were raised at the handovers.

The midwives used early interventions with vulnerable women and those with complex social needs. This included women with known substance misuse, domestic abuse, trafficked women and those who were known to local authority safeguarding services. Early intervention meant that women with particular vulnerabilities were identified and referred or signposted to other support services.

The staff we spoke with told us they did not have a named safeguarding midwife lead which was not in line with the intercollegiate document, Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019). This guidance requires that NHS trusts providing maternity services has a named professional, who has completed child safeguarding training at level 4, in order to support staff and participate in case reviews and develop action plans. Following the inspection, the trust told us they had a safeguarding lead who had completed training in safeguarding at level 4.

Midwives had completed training on how to recognise and report abuse, and they knew how to apply it. The trust had set a target for 85% for training in safeguarding. Midwives had achieved compliance of 86% in level 3 safeguarding training.

The trust provided medical staffing data in the routine provider information request under the gynaecology core service. Therefore; we were unable to analyse data specifically for medical staff within the maternity core service. The trust could not assure us that medical staff had the required training and competencies to safeguard women and babies receiving care.

When safeguarding issues were identified or suspected, staff followed trust policy and processes. They completed a safeguarding referral form which was sent to the safeguarding team. The community midwives told us they would make their referrals from the main hospital or at the community hubs. The trust had made 388 referrals to the Multi Agency Safeguarding Hub (MASH).

Staff followed the trust procedure on reporting female genital mutilation (FGM). The Intercollegiate Report ‘Tackling FGM in the UK’ Advise (RCM 2013) states it was the responsibility of healthcare professionals to monitor and report FGM as part of children safeguarding obligations. Women were assessed for female genital mutilation at their first contact and antenatal appointments. Staff were able to tell us of action they were required to take to safeguard these women.

It has been mandatory since September 2014 for all acute trusts to provide a monthly report to the Department of Health on the number of women who have had female genital mutilation (FGM) or who have a family history of FGM. In addition, where FGM is identified in NHS women, it is mandatory to record this in the patient’s health record. A mandatory reporting duty includes cases of FGM in under 18-year-olds which came into force in October 2015. This dataset supports the
Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England.

The trust submitted data input into the NHS Digital female genital mutilation (FGM) database. The UK government is committed to preventing and ending female genital mutilation in the UK.

Staff confirmed that they had undertaken PREVENT training (The Counter Terrorism and Security Act 2015) introduced the PREVENT duty for various bodies to stop vulnerable people being exploited and drawn into terrorism. Data from the trust showed 92% of staff had completed PREVENT training.

The trust set a target of 85% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from 01 April 2019 to 21 July 2019 at trust level for midwives in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>01 April 2019 to 21 July 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>233</td>
<td>233</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>233</td>
<td>233</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>127</td>
<td>128</td>
<td>99.2%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Prevent Basic Awareness</td>
<td>226</td>
<td>233</td>
<td>97.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>152</td>
<td>174</td>
<td>87.4%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>130</td>
<td>150</td>
<td>86.7%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>129</td>
<td>174</td>
<td>74.1%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for six of the seven safeguarding training modules for which registered midwives in maternity at Queen Alexandra Hospital were eligible. The trust could not demonstrate how they gained assurance that medical staff had completed the required levels for safeguarding training in order to protect women and babies in their care. Following the inspection, the trust told us provided medical staffing data in the routine provider information request under the gynaecology core service. Therefore; we were unable to analyse data specifically for medical staff within the maternity core service.

Medical staff we spoke with were aware of their responsibilities in raising any safeguarding concerns to protect women and babies.

**Queen Alexandra Hospital**

A breakdown of compliance for safeguarding training courses from 01 April 2019 to 21 July 2019 at trust level for midwives in maternity at Queen Alexandra Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>01 April 2019 to 21 July 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>100</td>
<td>100</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>145</td>
<td>145</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>145</td>
<td>145</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Training module name</td>
<td>01 April 2019 to 21 July 2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Prevent Basic Awareness</td>
<td>142</td>
<td>145</td>
<td>97.9%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>116</td>
<td>127</td>
<td>91.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>89</td>
<td>103</td>
<td>86.4%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>97</td>
<td>127</td>
<td>76.4%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for six of the seven safeguarding training modules for which midwives in maternity at Queen Alexandra Hospital were eligible. The compliance rate for level 2 safeguarding training was 76% and below the trust target.

No medical staff data was available for maternity between 01 April 2019 and 21 July 2019.

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

**Cleanliness, infection control and hygiene**

Staff mostly used equipment and control measures to protect patients except for the birthing pool where cleaning procedures were not effective. They kept themselves and premises clean.

The maternity unit was visibly clean, tidy and uncluttered. We saw staff followed cleaning procedures with bed and couch spaces cleaned in-between patients to minimise the risks of cross infection.

There were no methicillin-resistant Staphylococcus aureus (MRSA) or clostridium difficile cases reported in the maternity services according to trust data during the year preceding the inspection. MRSA is a bacterium responsible for several difficult-to-treat infections and clostridium difficile is an infective bacterium that causes diarrhoea.

On the labour ward, we found the birthing pool had a build-up of limescale and adequate cleaning could not be assured. This may put mothers and babies at risk of cross infection, as the trust could not be assured cleaning of the birthing pool was adequate or in line with infection control and prevention policy to safeguard women and babies.

The guidelines used by staff for dilution of the cleaning fluid and timings for soaking were unclear and contradictory as there were two sets of different instructions in use. This meant staff may be following an inconsistent approach in cleaning the pool and not in line with current procedures.

Staff told us they used gloved hands to remove debris from the pool; good practice guidance recommends the use of a sieve and this was not available to staff, we brought this to the attention of a senior staff member during the inspection and the trust sent us a copy of their revised waterbirth pool cleaning instructions. The revised guidelines did not address the issues such as use of personal protective equipment and removal of debris from the birthing pool.

There were no records of the birthing pool outlet and taps being flushed, in line with guidance on the prevention of legionella infection. Following the inspection, the trust told us two of the birthing pools were not included in the routine flushing programme because they are in more than weekly use. The Staff were unable to tell us about this and we found the outlet was not clean. Staff told us the pools were cleaned after each use but there were no audits or records of this. In response to our concerns, the trust told us the cleaning schedules for all ward areas offering water births had been updated to include daily cleaning, and these commenced on 25 October 2019. The trust also said in the future this would include birthing pool cleaning.
The maternity service carried out regular cleaning audits using the National Specification for Cleanliness in the NHS audit tools. There was documented evidence that the quality of cleaning was reported and that any necessary repairs or action was dealt with.

Clinical staff were required to comply with the ‘Five moments for hand hygiene’, as set out by the World Health Organisation (2009) and the trust’s own hand hygiene policy which followed National Institute for Clinical Excellence (NICE) guidelines. We saw staff cleaning their hands and used hand gels in between patients. Hand hygiene audits for the last six months showed staff were between 91% and 98% compliant, in line with the trust target.

We saw that midwifery staff were bare below the elbows when working in the clinical environment. Hand gels were available at the entrance to the unit including gels which were dispensed on contact with the door handle in the entrance to the labour ward. There was signage which advised staff and visitors to use hand gels provided when accessing the unit and the wards.

Midwives who worked in the community and attending home births were provided with hand sanitiser, and the personal protective wear required to ensure effective infection control procedures were followed.

There was a system to identify equipment that had been cleaned and ‘I am clean stickers’ were used. This was monitored and record from September 2019; Safety huddle leads reminded staff to use the green label every time that equipment had been cleaned.

The maternity service followed the Department of Health’s guidance, ‘Implementation of modified admission MRSA screening guidance,’ (2014). This recommended all women admitted to high risk units and all women previously identified as colonised with MRSA should be screened for MRSA. In addition, local risk assessment should be used to define other potential high MRSA risks. In line with the target of zero there were no reported cases of MRSA from July 2017 in maternity. There were no cases of Clostridium Difficile in maternity between July 2017 and June 2018.

Sharps were managed in line with national guidance. We saw sharps bins were available in treatment areas. This was in line with Health and Safety Regulations 2013 (The Sharps Regulations). This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, showing the date it was put together, by whom and on what date.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe but the facilities in the maternity assessment unit did not always meet the needs of women.

The environment in the maternity assessment unit (MAU) was cramped with a lack of suitable facilities for women and their relatives attending the service.

The women told us the room was not fit for purpose with equipment overhead and seats underneath which may pose a safety risk. Staff told us the waiting room was not suitable as this was previously used as a clinical room. This had been raised with the trust and they told us the trust were looking at alternative accommodation and there were currently no firm plans.
There was a lack of seating and the women found the seating that was provided was small, uncomfortable, and did not meet the needs of pregnant women. During the inspection we observed there were 14 women and relatives in the waiting room with some women standing as there were no seats available for them.

The women told us they attended the MAU on a regular basis for monitoring and could spend up to four hours in the unit. There was no facility to buy drinks, although staff provided jugs of water in the waiting area.

There was a risk that in an emergency staff might not know the best way to provide assistance to women in the birthing pool. Staff also told us they had not received training in the use of the hoist in the birthing pool rooms. The birthing pools had ceiling tracks and staff told us there should be manual and hoist slings for the emergency evacuation of women and babies from the pool. In the labour ward, staff were unable to locate the types of slings which would be needed. In the maternity co-located unit, staff were also not aware of the different types of slings and we found there were two slings in the cupboards which were labelled as manual and hoist slings.

The reception to the maternity unit was staffed twenty-four hours a day, seven days a week. The entrance was secure, and relatives and visitors were required to check in at reception when they arrived at the unit. The trust had a system which flagged up vulnerable women and those who were not allowed access to the women and babies. Where there were known risks for individual women, the reception staff checked certain visitors’ identification before allowing them in the unit. However; after 8pm they managed the main reception and also the entrance to B7. This may be a weakness in the system as staff would not be able to carry out ID checks. There was also no emergency button at reception for staff to seek assistance and raise the alarm in an emergency.

The maternity unit was well maintained, and the accommodation was spacious and well equipped to meet the needs of women. Women were accommodated in single rooms with appropriate en-suite facilities. Equipment was well maintained, and the rooms were equipped with cots, suction, oxygen and gas and air.

The neonatal intensive care unit (NICU) was situated close to the labour ward and the co-located birth centre. Pre-term babies or babies requiring special care were transferred from the labour ward.

The neo-natal emergency trolley was located between the labour ward and the NICU which made it readily accessible in an emergency. The neo-natal resuscitation trolley was maintained securely with tamper evident tags. The adult resuscitation trolley was of a different type and not tamper evident, which meant that equipment could be missing, when needed. Emergency drugs were available in sealed boxes which were checked daily. The emergency resuscitation trolleys were checked daily in line with the trust policy and records showed these were followed.

The community midwives were issued with homebirths kits. Records showed staff adhered to the policy on equipment checks and these were completed to ensure equipment was ready and fit for purpose.

Staff had raised concerns as the homebirth kits were heavy and cumbersome which may pose health and safety risks for the staff. Midwives told us they were seeking moving and handling advice with the aim of submitting a bid for bags with wheels.
There were designated operating theatres for maternity which were also close to the labour ward. A senior staff member told us they occasionally needed to use the main theatre which was on a different floor. There was no dedicated lift. However, there was a facility to override the passenger lift if this was required in an emergency and staff told us this would mitigate any risks of delays in transferring women to the operating theatre.

**Assessing and responding to patient risk**

**Staff mostly completed risk assessments for women to mitigate risks. Assessment of women in the MAU was not always carried out in a timely way.**

The maternity assessment unit (MAU) used the Wessex Ante-natal Pathway for the assessment of women. Women contacted the labour line and, following triage, attended MAU, if necessary. The Wessex pathway consisted of detailed information and guidance and followed a red, amber, green (RAG) rating system to ensure women received timely care when they attended the MAU.

The trust guideline showed that an initial assessment by the MAU midwife should be carried out within 30 minutes of arrival of those women presenting with possible obstetric complications including the use of Wessex Pathways for assessment of women. All women should receive an initial assessment to enable a RAG rating to be completed.

During the inspection we found this was not followed and women had waited for two hours without being assessed and had not been given a RAG rating. Failure to follow the trust procedures meant risks to women and babies were not identified and managed in line with the trust’s guidance to staff. We raised this with the trust during our feedback, so that action could be taken. Midwives told us that staff shortages and the volume of women who were triaged and sent to the unit posed clinical safety risks.

Following the inspection, we received a snap shot data audit for MAU, this showed women waited an average of between one hour 40 minutes to five hours and 30 minutes and shortest waiting times of 30 minutes. The action plan developed in October 2019 showed the trust was investigating a different location exploring funding options to introduce the role of advanced midwifery practitioner to improve the waiting time and the woman’s experience.

We observed the process for the World Health Organization (WHO) ‘Safer Surgery Checklist’. The aim of the WHO checklist is to reinforce accepted safety practices and foster better communication and teamwork between clinical disciplines. Staff told us the sign in process was variable. It could be done outside the theatre or inside depending on the anaesthetist which was not a consistent approach. During the inspection, the safety checklist was completed although there was a radio playing in the background which could be a potential source of distraction. Use of the checklist process promotes patient safety and any failure to do so presents a risk of errors within the theatre environment. The obstetric theatres had completed an audit of the use of the checklist. The outcome of the observational audit for the last six months showed compliance between 92% and 100%.

Midwives and doctors used a standardised communication tool Situation, Background, Assessment, Recommendation (SBAR) when any woman was transferred in and from outside the unit. This facilitated safe ongoing management of the women’s care.
Midwives monitored women’s baseline observations such as blood pressure, weight and foetal growth at each appointment. They reassessed other risk factors such as foetal movement or perinatal mental health, as appropriate. The risk assessment process included an escalation procedure to refer women to an obstetric consultant team. This included women with increased risks of high blood pressure and gestational diabetes.

Midwives and obstetric staff completed the modified early obstetric warning score (MEOWS) system to record observations. This was used as standard baseline observations of women on admission to the unit. This enabled staff to recognise acute illness and support staff to escalate appropriately.

The trust had a sepsis protocol, and we saw that this was used, when necessary. Where sepsis was suspected patients had blood cultures taken as part of the diagnosis in order to identify whether they had a blood stream infection. The ‘golden hour’ was followed in maternity, the principle was the initiation of antibiotics given within an hour of severe sepsis diagnosis.

Midwives working on the labour and induction wards used ‘fresh eyes’ approach for foetal monitoring. This involved a second midwife checking recordings from the cardiotocograph (CTG) machine to ensure any anomalies in the foetal heart trace had not been missed.

There was a blood fridge in theatre with two units of O negative blood for mothers and two for babies. There was a pathway for anaesthetist to attend for complex cases or major obstetric haemorrhage (MOH). Staff told us they had used the 4444 call for MOH which worked well and had rapid access to blood products as needed.

The trust had two specialist perinatal mental health midwives and a safeguarding operational lead. They had recently launched the changing outcomes, relationships and lives (CORAL) team. The CORAL midwives worked closely with the lead to support women with severe mental health problems and other needs such as anxiety, depression, bipolar disorder and puerperal psychosis. Some of these conditions which may develop during antenatal or post-natal period.

The mental health perinatal mental health midwives completed a care plan with the women and this was in the first-person using language the women would understand, the women agreed the plan of care and were given a copy. This was also shared with other professionals involved in their care with the women’s consent. The team supported women to stay on their regular medication during pregnancy.

The team had regular meetings with the women and their partners (as appropriate) and developed a plan of care. At 34 weeks an emotional wellbeing assessment was drawn up and care plans for birth were initiated. Women were risk assessed at every antenatal appointment and a plan of care was documented in their hand-held records.

Staff had undertaken newborn life support (NLS) courses. This allowed staff to provide care to seriously ill babies. The neonatal care unit (NICU) was available to provide care to those babies needing higher levels of care and treatment.

**Midwifery and nurse staffing**
The service did not always have enough midwifery staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The table below shows a summary of the midwifery metrics in maternity at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>326.6</td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td></td>
<td>7%</td>
<td>12%</td>
<td>6.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>208.9</td>
<td>7%</td>
<td>11%</td>
<td>5.7%</td>
<td>24,716 (73%)</td>
<td>103 (&lt;1%)</td>
<td>9,246 (27%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Midwifery staffing rates within maternity were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank use or agency use.

Monthly vacancy rates over the last 12 months for, health visitors and midwives show a shift from December 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from November 2018 to May 2019.

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

Queen Alexandra Hospital

The table below shows a summary of the midwifery staffing metrics in maternity at Queen Alexandra Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>206.9</td>
<td>7%</td>
<td>11%</td>
<td>6.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>128.4</td>
<td>7%</td>
<td>11%</td>
<td>5.1%</td>
<td>24,146 (72%)</td>
<td>103 (&lt;1%)</td>
<td>9,103 (27%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Midwifery staffing rates within maternity at Queen Alexandra Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank use or agency use.
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives show a shift from December 2018 to May 2019.

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

Monthly sickness rates over the last 12 months for health visitors and midwives show a downward trend from November 2018 to March 2019.

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

From January 2018 to December 2018 the trust had a ratio of one midwife to every 27.1 births. This was about the same as the England average of one midwife to every 24.6 births.

(Source: Electronic Staff Records – EST Data Warehouse)

The midwife to birth ratio from April and September 2019 varied between 1.27 to 1.31, this was below the England average.

The maternity service did not always have enough midwifery staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
Maternity services used the ‘safer staffing’ tool to assess the midwives’ capacity required on each shift. Staffing by band was displayed on each ward area with the planned and actual numbers shown. A senior staff member told us staffing was reviewed daily to achieve staffing levels and skill mix in the unit.

The maternity dashboard red, amber, green (RAG) rated key performance indicator recorded the midwife to birth ratio as 1:31 for a green flag, (this means there was 31 births to one midwife), and 1:34 for a red flag. This was based upon a Birthrate Plus assessment, a workforce planning tool that enables midwives to justify their decisions on the best size and mix of the midwifery workforce. However, the trust maternity dashboard used to monitor key performance indicators (KPI) indicated that the ratio of 1:31 was met from April 2019 to September 2019, with the exception of August 2019.

There was a process for escalation within the unit in order to mitigate risks and ensure that women received timely care and treatment. This was not used effectively in the MAU where some women had waited for two hours without being assessed.

Staff told us there was not always adequate staff with the skills to meet women and baby’s needs. This was particularly in the MAU and the co-located midwife- led unit. Staff told us women in the community were asked to call the unit for advice or if they needed to come in. However; there was not always a midwife on shift in order to answer their queries. This meant calls had to be transferred to the labour ward which caused delay and distress for the women.

The data audit for 1:1 care for labouring women showed that between March 2019 to September 2019, 96% of women received 1:1 care for deliveries.

<table>
<thead>
<tr>
<th></th>
<th>1 to 1 care during labour and birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>97</td>
</tr>
<tr>
<td>Unknown</td>
<td>10</td>
</tr>
<tr>
<td>Yes</td>
<td>3026</td>
</tr>
<tr>
<td>Blank</td>
<td>18</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>3151</strong></td>
</tr>
</tbody>
</table>

**Medical staffing**

The trust did not provide data on medical staffing for maternity between 01 April 2019 and 21 July 2019 and we are unable to report on this. The trust told us they provided medical staffing data in the routine provider information request under the gynaecology core service. Therefore, we were unable to analyse data specifically for medical staff within the maternity core service.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Following the inspection, we requested and received data on medical staff hours for the month of October 2019. The data is presented in the table below.
<table>
<thead>
<tr>
<th></th>
<th>y</th>
<th>y</th>
<th>y</th>
<th>y</th>
<th>LW8.15 – 17.00</th>
<th>LW8.15 – 17.00</th>
<th>LW8.15 – 17.00</th>
<th>LW8.15 – 17.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot days</td>
<td>LW 8.15 – 17.00</td>
<td>LW 8.15 – 17.00</td>
<td>LW 8.15 – 17.00</td>
<td>LW8.15 – 17.00</td>
<td>LW8.15 – 17.00</td>
<td>LW8.15 – 17.00</td>
<td>LW8.15 – 17.00</td>
<td></td>
</tr>
<tr>
<td>Night on call</td>
<td>LW 17.00-20.30</td>
<td>LW 17.00-20.30</td>
<td>LW17.00-20.30</td>
<td>LW17.00-20.30</td>
<td>LW17.00-20.30</td>
<td>LW17.00-20.30</td>
<td>LW17.00-20.30</td>
<td></td>
</tr>
<tr>
<td>Non-resident On call</td>
<td>22.30 - 8.00 +1day</td>
<td>22.30 - 8.00 +1day</td>
<td>22.30 - 8.00 +1day</td>
<td>22.30 - 8.00 +1day</td>
<td>22.30 - 8.00 +1day</td>
<td>22.30 - 8.00 +1day</td>
<td>22.30 - 8.00 +1day</td>
<td></td>
</tr>
</tbody>
</table>

Key:
- **Green** – hours of labour ward Consultant presence
- **Red** – hours that are not covered by Consultant presence
- **Yellow** – on call

Total labour ward cover on labour ward = 66 hours

Consultants had 66 hours presence which was lower than the 98 hours recommended by the Royal College of Obstetricians and Gynaecologists (RCOG). This was on the trust risk register and needed four consultants to achieve this. Staff told us that a business case had been submitted for one additional consultant which was in the process of being approved.

There were three Anaesthetists who covered the labour ward, (including theatre emergencies) and elective activity and a trainee. The third anaesthetist reviewed all women the next day after the caesarean section with the trust data showing 95% of follow ups achieved.

The trust had a total of 17 Obstetricians and gynaecologists. There was one Obstetrician and one Registrar who covered the daytime hours and two were on at night. There was also one senior house office (SHO) who covered the wards separately to the labour ward SHO.

Staff told us there were issues with middle grade staffing with consultants having to step down at least 1-2 times per month.

On Saturdays, Sundays and bank holidays a consultant was on site for three hours per day. There was a junior doctor cover on Saturday and Sunday for ward rounds, discharges. A consultant or senior registrar covered elective caesarean sections from Monday to Friday. A junior doctor also assisted.

The trust allocated evenings and weekend days on a rotational basis. During the week there was no consultant presence on the labour ward between 21:00 and 08:00. At weekends there was no consultant presence between 10:30 and 20:30 or 21:30 and 08:00. They were on call and attended the service when needed.

Midwives and junior doctors told us senior managers and consultants were supportive and accessible. Staff said they could escalate staffing concerns and were confident these would be addressed.
Consultants who did not live within 30 minutes of the hospital, when on call, would stay on site or in the vicinity of the hospital.

In April 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

**Staffing skill mix for the 36.4 whole time equivalent staff working in maternity at Portsmouth Hospitals NHS Trust.**

![Staffing Skill Mix Chart](chart)

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>46%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

**Records**

Staff kept some detailed records of patients’ care and treatment. However not all records were kept securely, and records assessments were not consistently maintained.

The trust had a paper-based record system, comprised of two different formats. Staff told us they had not received training when the new record system was recently introduced, senior managers told us the trust was planning to introduce an e-record system.

There was a risk of records being mislaid and mixed up with other women’s records as these were not bound and secure. In the labour wards, we found some CTGs and other records of women were loose in envelopes. Dates on envelopes did not coincide with CTGs. Blood gas results were also found in the CTG envelopes. Some of the staff reported difficulty navigating through women’s records and could not locate plans and assessments easily due to the two records formats which were in use.

We reviewed 16 sets of women’s records and we found the recording of the women’s pathway was inconsistent. The records followed the maternity pathway with proformas which included an antenatal, labour, theatre module and a postnatal care. Records showed assessment had been completed including, where appropriate, physical health, mental health and any social needs of women. Care plans were completed and reflected the individual woman’s needs as identified during the initial assessment. Care plans were personalised, risk assessments and results were documented.
Although some women’s records were fully completed, there were some inconsistencies in assessments such as venous thromboembolism (VTEs) were not completed in all records. The surgical WHO checklist was not fully completed such as sign out in two records we reviewed.

Women received the personal health record (the ‘red book’) to keep details of their baby’s development and took this with them to all future baby appointments and reviews.

On discharge home, a summary letter was sent to the GP, and staff said a copy of the letter was also kept in the women’s records.

**Medicines**

*The service used systems and processes to safely prescribe, administer, record and store medicines.*

The maternity unit received timely supply of medicines and had access to medicines when the pharmacy was closed. Staff said they received good clinical pharmacy support.

We carried out a random review of medicines in the maternity unit and found medicines were stored safely and securely. Medicines were checked regularly, and these were within their expiry dates. We saw all drugs in the controlled drug (CD) cupboard were in date, checked daily and signed this was completed. Staff followed the trust process for controlled drugs to ensure women received their medicines safely.

The medicines room was secure with restricted keypad entry. This contained two medicine fridges. One of these was locked and the other fridge was unlocked as staff said they needed to have quick access to a medicine used for managing major bleeds. Staff told us the keypad numbers were not changed at intervals as recommended and this may pose risk to unauthorised people having access to the clinical room and medicines.

Staff monitored the fridge temperature daily and records were maintained. This ensured medicines were kept as recommended and maintained their efficacy. Medical gases were available for women such as gas and air and these were either piped or on mobile trolleys. Oxygen cylinders were maintained safely on the emergency trolleys and these were within their expiry date.

The trust had midwives’ exemptions policy and procedures which was ratified in May 2019 and a review date for 2020. Medicines falling within these exemptions allowed midwives to supply and administer medicines without a prescription or patient specific direction.

Medicines not included in the midwives’ exemptions required Patient Group Directives (PGDs). This allowed midwives to administer some medicines and was in line with maternity exemption (ME) protocols. Patient Group Directives (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). Supplying and/or administering medicines under PGDs should be reserved for situations in which this offers an advantage for patient care, without compromising patient safety.

The trust had developed the required PGDs to support the staff to administer and supply medicines, following training in line with the Nursing and Midwifery Council Code of Professional standards. Trust data showed that 94% of midwives had completed training in the use of PGD’s, which was delivered on the maternity trust update sessions. The trust told us the newly appointed midwives and band 5 midwives had PGD training as part of the preceptorship programme and signed the PGD registers.
Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses.

The trust could not be sure incidents were reviewed in a timely manner in order for actions to be taken and this could affect outcomes for women and babies. At the time of the inspection staff told us there was a backlog of around 120 plus incident reports which were open. A senior midwife told us they had 20+ incidents which had been allocated to them and they did not have the time to review them.

Staff understood their responsibility to raise concerns, record and report safety incidents, and near misses. There was a culture of incident reporting across the unit. Staff used the electronic reporting system to record incidents. However, staff said they did not have time to always complete incident forms as they were busy particularly when they were short of staff.

Staff in the community could not record incidents in a timely way. This was due to the lack of IT availability in the community. Staff told us that although incidents were reported, reporting could only be completed by coming into the hospital.

Staff we spoke with across the unit and in the community told us they did not always receive feedback when they reported an incident and felt learning from incidents could be improved. There were missed opportunities for shared learning as there was no newsletter although feedback was provided at safety huddles. Staff told us information sharing was not always effective such as if midwives were on leave, they would not receive this information. The trust were looking at developing newsletter as one of the methods of communication for staff. Following the inspection, the trust told us feedback was available on the shared drives.

Incidents and lessons learnt were shared at the staff daily handover meetings, weekly safety huddles meeting and at the monthly risk meetings where all incidents, themes, actions and the risk register were discussed.

Records of safety huddles received from the trust following the inspection showed some learning was shared. For example, staff were reminded to complete neonatal observations and escalate any abnormal result and actions as per guidance, and to document in the babies notes that they had escalated to a named person. The trust could not be sure incidents were actively recorded to inform safety management and improve practices and outcomes for women.

During the inspection, we reviewed whether staff had completed an incident record following lack of staffing which impacted on women and babies not receiving timely assessment. We found an incident report had not been raised as staff said they often did not have time to report incidents particularly staffing incidents.

The maternity service had set up an incident monitoring group in October 2019 to review submitted safety learning events forms. The aim was to review the cases in a timely manner, identify emerging themes and trends in maternity service. It was planned that the findings would be shared with the local maternity system governance group to support learning and changes to improve practice.

The severity of an incident was graded using the National Patient Safety Agency framework; these were no harm, low harm, moderate harm, severe harm. The clinical governance midwife reviewed
all incidents. The matrons monitored incident investigations and action plans were developed following incident investigations. The community matron had overview of incidents and liaised with governance team to receive updates on incidents within the community setting which were outstanding.

Serious incident investigation reports included detailed accounts of conversations with women and families in accordance with the duty of candour. The reports also included records of how learning from incidents would be shared; these included clinical governance meetings, divisional meetings, ward meetings.

There were monthly perinatal mortality and morbidity meetings. The meetings were attended by the director of midwifery, consultant obstetrician, registrars, midwives, bereavement midwives.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

The trust reported no never events in maternity from August 2018 to July 2019.

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

We reviewed the three recent safety incidents (SIs) as reported by the trust. Two were completed by the Health Service Investigation Branch (HSIB) under the Each Baby Counts scheme. The remaining report was produced by trust investigators under the usual SI process and reported to the clinical commissioning group (CCG). Following the investigations, the trust was required to produce an action plan and update recommendations.

Following root cause analysis of SIs, reports of investigations were reviewed by the Maternity Governance Forum. They allocated this to the appropriate professional to implement associated action plans. The Maternity Governance Forum then oversaw delivery of the actions by the named professionals.

Staff understood their responsibilities in relation to the Duty of Candour and told us they were open and transparent with patients and their families, if something went wrong. 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.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2018 to July 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>2</td>
<td>40.0%</td>
</tr>
</tbody>
</table>
### Incident type

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother only</td>
<td>2</td>
<td>40.0%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

### Safety thermometer

**Staff collected safety information and shared it with staff, patients and visitors.**

The maternity service did not participate in the NHS safety thermometer. This measurement/improvement tool focuses on perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.

The tool allowed teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced ‘harm free’ care. It supported improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines.

Following the inspection, we requested information regarding the maternity safety thermometer. Maternity services did not use maternity safety thermometer. The trust used the classic safety thermometer which did not provide data that was maternity specific. Outcomes measures included: Harm free care; hospital acquired venous thromboembolism (VTE); hospital acquired pressure ulcers; hospital acquired catheter urinary tract infection (UTI); and falls with harm. We reviewed data from October 2018 to October 2019, the service regularly achieved 100% harm free care in relation to the outcomes measured by the classic safety thermometer.

### Is the service effective?

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice**

The trust had systems to ensure care and treatment was managed in accordance with national guidance. Maternity and obstetric staff worked in accordance with the Royal College of Obstetricians and Gynaecologists (RCOG) ‘Safer childbirth: minimum standards for the organisation and delivery of care in labour’ and the National Institute for Health and Care Excellence (NICE) guidance.

Midwives told us that normalisation of births were encouraged and supported in line with midwife led pathway. Staff promoted skin-to-skin contact between mother and baby particularly following a caesarean section, in line with NICE Clinical Guideline 190: Intrapartum care; care of healthy women and their babies during childbirth.
Midwifery staff followed guidelines in line with the World Health Organisation (WHO 2013) to support staff in recognising the types of female genital mutilation (FGM). The guidelines supported staff in providing safe care and identify women who had been subjected to FGM and those at risk at an early stage.

Care was tailored to the women’s holistic needs; this was evident from feedback we received from several midwives. Foetal growth was monitored from 24 weeks by measuring and recording the symphysis fundal height (from the top of the mother’s uterus to the top of the mother’s pubic bone) at each midwifery appointment. This was in accordance with MBRRACE-UK 2015 and NICE CG62 antenatal care for uncomplicated pregnancies 2018 guidance.

Staff used the national Gestation Related Optimal Weight charts (GROW), in accordance with the Perinatal Institute recommendations. Adjustment for the GROW variables improves the recognition of babies that are pathologically small or growth restricted.

The maternity service carried out detailed ultrasound in the first and second trimester of pregnancy. Foetal growth restriction is associated with stillbirth, neonatal death and perinatal morbidity. This approach helped midwives identify growth retardation. If they had concerns, they referred women for further scans and follow up appointments as needed.

Women accessed antenatal appointments in line with the NICE Antenatal Care Quality Standard 22. This quality standard covered the antenatal care of all pregnant women up to 42 weeks of pregnancy.

Babies born with tongue tie were seen in midwife-led clinics. Midwives had been trained to treat tongue tie in babies.

Babies were assessed for jaundice and treated in line with NICE guideline QS57. The trust had well established special interests’ clinics such as diabetes, maternal medicine, multiple pregnancies, pre- term births, perineal clinic which included third degree tear.

Policies and procedures were available on the trust’s intranet and those reviewed reflected current national guidance and best practice. There was a system for ensuring policies were reviewed in line with guidance changes, and prior to policy expiry dates. Intrapartum Care policy was ratified in April 2017 due for review May 2020. Foetal monitoring guideline was ratified in February 2019 and due for review October 2021. Diabetes in Pregnancy ratified in December 2018 and due for review in October 2021.

Medicines administered under PGDs included oral morphine sulphate solution. The PGD had a review date of April 2019 and there was no evidence of recent review of this document. The PGD for Prostin was due to be reviewed in November 2019.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health**

Women were offered a choice of diet and fluids which they said met their needs. Hot and cold drinks were available at all times and women were also offered snacks outside of set meal times.

The maternity unit employed infant feeding specialists and provided breastfeeding clinics and drop-in sessions. This service was available Monday–Saturday providing support to women in the
community. Women were supported in the community by infant feeding team support workers. These staff were attached to the community teams and offered support and guidance for women feeding either on the breast or bottle.

Patient information on breastfeeding support was seen throughout the department. All women we spoke with said they had received support to breastfeed soon after birth, and that this had continued on the post-natal ward.

Midwives assessed how women managed to feed their babies following birth and again at the subsequent post-natal appointments. The records booklet included a breastfeeding assessment form.

The NHS performance data for breastfeeding showed at six to eight weeks after birth the trust rate for women who had initiated breastfeeding. There were 23% of women had not breastfed, and an average of 36% of women totally breastfed. This was lower than the England average (Source NHS England 2017-2018).

Expressed breast milk was stored safely and securely in a milk kitchen with a dedicated locked fridge which had its temperature monitored daily.

Artificial feeds were available to women wishing to bottle feed their babies. A choice of formula milk was provided to mothers who needed to bottle feed their babies.

The maternity services were not accredited with UNICEF baby friendly initiative. The trust told us they were working towards accreditation. UNICEF baby friendly initiative supports breastfeeding and parent infant relationships by working with public services to improve standards of care. The NHS Long Term Plan recommends UNICEF UK Baby Friendly accreditation across all maternity services and includes a focus on improved support for families with infants in neonatal care.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We viewed a range of policies on the management of pain to ensure the trust met the ‘Core standards for pain management services in the UK.’ This included a guide for staff on pain assessments.

Midwives assessed women’s pain regularly and there was guidance for staff on the administration of analgesia. We spoke to several women during our inspection and all reported their pain was managed well.

Women had access to a range of pain relief methods following NICE guidance CG190. This included (gas and air) and morphine-based drugs which were available as an oral solution and injections.
Epidurals were available 24 hours seven days a week. Staff told us women generally received epidurals within 30 minutes of request. Following the inspection, the trust told us that the average wait for an epidural was 4.6 minutes. Training and support were provided by anaesthetic staff.

Patient controlled analgesia equipment was available to enable women to control the amount of pain relief they required.

Alternative pain relief was available. Women also had access to a birthing pool, birthing balls and bean bags.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment.**

Maternity services had a dashboard to monitor key performance indicators (KPIs). The dashboard was ‘red, amber, green’ (RAG) rated. For example, the dashboard recorded the rate of third- and fourth-degree perineal tears during labour. A perineal tear is a laceration of the skin and other soft tissue structures which, in women, separate the vagina from the anus. The threshold for a red rating on the dashboard for a third- or fourth-degree tear, spontaneous vaginal delivery (SVD), was 3.5%.

The dashboard for the rate of third- and fourth-degree tears was RAG rated ‘amber’ between April 2019 to September 2019 and this was between 1.6 and 2.8%. The RCOG guidelines, ‘Third- and Fourth-degree Perineal Tears, Management (Green-top Guideline No. 29), 2015,’ state the “overall incidence in the UK is 2.9%.” We found the trust’s incidence was consistently lower than this during the reporting period.

Midwives followed a pathway developed for women with raised BMI over 30 which included weight measurements at booking, at 16, 28 and 36 weeks, they had ultrasound scans and dietary advice were given.

Between April 2019 and September 2019, the trust had treated between 7% and 28% of women with BMI of over 35-40. There were between 4% and 19% of women with a BMI between 40.5 and 50.

The trust maternity matters report 2019 showed midwives and health professionals were being trained to have better ‘healthy conversations’, enabling them to improve communication with women around areas of health such as raised BMI and smoking cessation.

The trust had between 7.7-11.2% of women who had instrumental deliveries, (Ventouse (suction) and forceps). Th 5.3% target had been met in all months in the period between April 2019 to September 2019 except for June where this was 6%. Maternity had met the trust’s 3% or below standard for failed instrumental deliveries leading to lower segment caesarean section in the same period.

The number of cases of meconium aspiration were mixed. This is a syndrome where a newborn has trouble breathing (respiratory distress) due to having aspirated a dark green, sterile faecal material called meconium into the lungs before or around the time of birth. The trust’s standard was that there should be no more than two cases per month. Between April 2019 and September 2019 there was no more than one case per month.
The trust had between 10 to 20 term babies >37 weeks gestation admitted to NICU unexpectedly. The highest number was in April 2019 at 20 babies. The trust had not set a target, and this was not RAG rated.

Maternity performed in line with the trust standard for spontaneous vaginal delivery of 66 to 82% between April 2019 and September 2019. The lowest rate of spontaneous vaginal delivery was 66% in July 2019.

Senior staff raised concerns about the increased activities in the maternity assessment unit (MAU) which was not in scope for this type of service. These included a number of elective activities such as scans reviews, iron infusion, external cephalic version (ECV) with limited staff workforce. This may negatively affect the care of women and babies attending the MAU.

The maternity dashboard did not report on maternity compliance with newborn and infant physical examination (NIPE) completed within 72 hours post birth between April 2019 and September 2019. We cannot report on compliance with newborn and infant physical examination (NIPE) completed within 72 hours post birth in the same period.

We found the trust was meeting its KPI of 2.1% for massive post-partum haemorrhages of 1,500 to 2,000 ml in the period April 2019 to September 2019.

Between April and September 2019 there were 2,301 births (83%) at Queen Alexandra Hospital and 364 (13.2%) babies were born at the co-located birthing unit on B5.

The maternity dashboard recorded did not record data for shoulder dystocia, (shoulder dystocia is when the baby's head has been born but one of the shoulders becomes stuck behind the mother’s pubic bone, delaying the birth of the baby's body).

The trust undertook an audit of 24 women’s records of the Modified Early Obstetric Warning Score (MEOWS) in October 2019 which showed 88% of women had had oxygen saturation and level of consciousness and their EWS calculated recorded on admission. The compliance rate for recording women temperature on admission was 92%. There was no documentation as to the reasons for incomplete set of observations, and EWS calculated.

An action plan had been developed which included Midwifery Practice Educators to include the following in the daily safety huddle for two weeks commencing 1st Nov 2019, and in the deterioration workshops on PROMPT from Nov 2019.

The table below summarises Queen Alexandra Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? (Antenatal steroids reliably reduce the chance of babies developing)</td>
<td>91.9%</td>
<td>Positive Outlier</td>
<td>Met</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Hospital performance</td>
<td>Comparison to other hospitals</td>
<td>Meets national standard?</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>respiratory distress syndrome and other complications of prematurity)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery? (Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)</td>
<td>71.9%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Neonatal Audit Programme)

The national neonatal audit data showed that the trust 91% for the national standard for mothers who delivered babies from 24 to 34 weeks gestation who were given a dose of antenatal steroids and this was a positive outlier. There is no current national standard or requirement for mothers who deliver babies below 30 weeks gestation being given magnesium sulphate. However, the trust was found to be within the expected range for this outcome in the NNAP 2018. In July 2019 the percentage of mothers being given magnesium sulphate had improved to 88%.

The table below summarises Queen Alexandra Hospital’s performance in the 2017 National Maternity and Perinatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard? (Delete tick or cross)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>103.8%</td>
<td>N/A</td>
<td>Met</td>
</tr>
<tr>
<td>Antenatal measures (before birth, during or relating to pregnancy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date (Babies who are small for their age at birth are at increased risk of problems before, during and after birth)</td>
<td>62.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Intra-partum measures (during labour and birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and)</td>
<td>38.1%</td>
<td>Higher than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Hospital performance</td>
<td>Comparison to other hospitals</td>
<td>Meets national standard? (Delete tick or cross)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>behaviour problems)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted overall caesarean section rate for single, term babies</td>
<td>28.9%</td>
<td>Higher than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>(The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7</td>
<td>1.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5 minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear</td>
<td>4.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1500 ml</td>
<td>3.7%</td>
<td>Higher than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-partum measures (following birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit</td>
<td>N/A</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Maternity and Perinatal Audit Programme)
The trust results for the National Maternity and Perinatal Audit Program were within the expected rates of babies who were small for their age at birth, or were at increased risk of problems before, during and after birth.

The audit also found the proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery was higher than expected. The rate for caesarean section for single term babies was also higher than expected.

The audit found women with severe post-partum haemorrhage of greater than or equal to 1,500 ml was 3.7% which was higher than expected. However, staff told us maternity had done a lot of work on post-partum haemorrhage and that high rates were as a result of the increased accuracy of estimates rather than under-recognition.

From January 2018 to December 2018 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections as expected.

<table>
<thead>
<tr>
<th>Standardised caesarean section rate (January 2018 to December 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of caesarean</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
<tr>
<td>Emergency caesareans</td>
</tr>
<tr>
<td>Total caesareans</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics (HES))

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.

In relation to other modes of delivery from January 2018 to December 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Proportions of deliveries by recorded delivery method (January 2018 to December 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivery method</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
</tr>
</tbody>
</table>
### Proportions of deliveries by recorded delivery method (January 2018 to December 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Portsmouth Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>480</td>
<td>9.5%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>3,030</td>
<td>59.8%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,065</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics (HES))

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
1Includes elective and emergency caesareans
2Includes forceps and Ventouse (vacuum) deliveries
3Includes breech and vaginal (non-assisted) deliveries

As of August 2019, the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES))

The maternity dashboard standard for elective caesarean section (CS) was 13%. The rate from April 2019 to September 2019 was consistently lower the trust’s standard at 12%.

The maternity dashboard standard for emergency caesarean section (CS) was 15%. Maternity had not met the trust’s standards from April 2019 to September 2019, RAG rated as amber for all the months except for June 2019 at 14.2%. The highest score was in May at 19.3%.

The normal vaginal birth after caesarean section (VBAC) trust standard was 65%. The results from April 2019 to September 2019 were encouraging as they varied between 66 and 82%.


<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts with similar service provision</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilised and risk-adjusted perinatal mortality rate</td>
<td>5.49</td>
<td>More than 10% lower than the average for the comparator group</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: MBRRACE-UK)
The trust used the MBRACE result to improve the outcome for women. The trust had identified some themes from the latest MBRACE data (December 2018-June 2019.) These included urine sample for asymptomatic bacteraemia at booking was not being undertaken, recording of carbon monoxide and domestic violence question were not recorded, and records that women had been given information about foetal movements. The trust had developed an action plan to address these shortfalls.

**Competent staff**

The service made sure staff were competent for their roles.

Midwives and obstetricians took part in annual skills and drill training for obstetric emergencies such as post-partum haemorrhage and shoulder dystocia. Midwives told us they participated in multidisciplinary training days to manage obstetric and neonatal emergencies in the community. The midwifery practice development team provided a range of workshops including: suturing skills, CTG groups, and bespoke training projects including, epidurals, cannulation skills. Staff had access to annual development days. Perinatal mental health awareness was a standard item on the agenda on these training days.

Midwifery staff had completed additional training as part of their practice and to meet the requirement of registration with the nursing and midwifery council (NMC). This included recognition of the deteriorating women, resuscitation of the new-born, obstetric skills, cardiotocograph (CTG). Staff told us this also included K2 training which is a perinatal training programme.

Staff had completed the annual Practical Obstetric Multi Professional Training (PROMPT) for obstetric emergencies such as shoulder dystocia, ante-partum and post-partum haemorrhage and maternal sepsis. This training provided staff with the skills and information on dealing with those type of emergencies and action they needed to take.

Midwives and obstetric staff undertook additional training in order to enhance their skills. Training included management of obstetric haemorrhage, and recognition of deteriorating patients; 95% of staff had completed this training. The midwifery team had achieved 93% attendance at Practical Obstetric Multi Professional Training (PROMPT) training.

The trust told us staff had completed six fire drills, three in the labour ward and three in community setting which included transfer of women from low risk to high risk setting. The trust told us that maternity services did not have a named practice midwife assessor (PMA). There were four midwives within the trust who had this qualification and supported staff. PMAs also supported women by listening to concerns they may have about their midwifery care. Staff told us the PMA role was new and some of the staff said they had not had any contact with the PMA.

New midwives joining the trust completed a comprehensive preceptorship programme. This included completing a midwife core competencies handbook. There were trust wide competencies for bands five to seven.

The trust had developed training for midwives as sonographers. Staff told us there was no GROW e-learning was currently available for midwives. Data from the trust showed 94% of midwives had completed this training.
The midwifery education team and other members of the maternity team attended ‘saving babies lives study day.’ This was to enhance staff skills and knowledge and reduce stillbirths. Staff told us that medics and midwives attended the study days and shared learning.

Consultant appraisals were managed centrally by the trust. Staff told us the consultants were engaged with the learning and development of junior doctors.

**Trust level**

From June 2018 to May 2019, 83% of required staff in maternity received an appraisal compared to the trust target of 85%. There were no appraisal data available for medical staff between June 2018 and May 2019. The trust told us they provided medical staffing data in the routine provider information request under the gynaecology core service. Therefore we were unable to analyse appraisal data specifically for medical staff within the maternity core service.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2018 to May 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>197</td>
<td>234</td>
<td>84.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>89</td>
<td>106</td>
<td>84.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>20</td>
<td>28</td>
<td>71.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>306</strong></td>
<td><strong>368</strong></td>
<td><strong>83.2%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

**Queen Alexandra Hospital**

From June 2018 to May 2019, 84% of required staff in maternity received an appraisal compared to the trust target of 85%.

Staff told us they did not always complete the appraisals which were cancelled due to acuity of patients and workload. Senior managers told us the trust was working at meeting the appraisal rate and this was raised at staff’s meetings.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2018 to May 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>123</td>
<td>143</td>
<td>86.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>53</td>
<td>63</td>
<td>84.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>16</td>
<td>22</td>
<td>72.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>192</strong></td>
<td><strong>228</strong></td>
<td><strong>84.2%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>
Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women including the community midwives.

Staff told us multidisciplinary team working in theatres was effective. We saw good interactions and communication within the operating theatre staff team.

We spoke with doctors, midwives, anaesthetists, housekeeping staff and reception staff who said they worked well together and felt part of the wider maternity team.

Community midwives rotated through the labour wards and this encouraged collaborative working and continuity of care for women using maternity services.

Maternity staff worked closely with staff from the neonatal unit. Neonatal unit staff told us they attended all births under 32 weeks gestation. The neonatal staff attended joint maternity service meetings to share information and learning. The Trust subsequently informed us that neonatal staff attended all births when clinically required. This included any birth occurring before 37 weeks gestation.

There were regular meetings with sonographers, midwives and the foetal medicines team senior midwifery staff to review women’s antenatal imaging/ scans.

The multi-disciplinary team which included a consultant obstetrician, foetal medicine associate, and a specialist midwife looked after women in their pregnancies from booking until delivery.

Seven-day services

Key services were available seven days a week to support timely care for women and babies.

The labour ward, co-located birth centre, theatres, MAU, antenatal, post- natal and the induction of labour ward operated 24 hours a day, seven days a week.

A consultant obstetrician was present on the maternity unit. On call consultant cover was provided after 10.30 pm till 8 am during weekdays and at weekends.

Community midwifery care and clinics ran between 8.30am and 5pm hours, seven days a week, outside of these hours an on-call service was provided.

The maternity unit had ultrasound scanners available that could be used out of hours if necessary. There were three dedicated obstetric theatres which offered 24-hour caesarean sections for planned and emergency.

The pharmacy service was available Monday to Friday Monday to Friday with a limited service at weekends and bank holidays and there was an on- call service at other times.
Health promotion

Staff gave women practical support and advice to lead healthier lives.
The trust had introduced the ‘saving babies lives care bundle.’ This was an initiative from NHS England (NHSE) to reduce stillbirths and early neonatal deaths. It brought together four elements of care based on: reducing smoking in pregnancy, risk assessment and surveillance for foetal growth restriction; raising awareness of reduced foetal movement, and effective foetal monitoring during labour.

At antenatal booking appointments women had a carbon monoxide exposure test and where appropriate referral to the smoking cessation service, in accordance with National Institute for Health and Care Excellence (NICE) 26, ‘smoking: stopping in pregnancy and after childbirth.’

A parent ‘red book’ was provided for each baby by the Health Visitor in the antenatal period. This was a parent held record and parents/ carers were encouraged to record health information in this book and have it available during appointments with midwives and other health professionals. Midwives promoted the benefits of skin-to-skin contact and breastfeeding support which had a positive effect on maternal well-being.

There was a variety of information leaflets available to mothers which included healthy eating, exercise and weight management during pregnancy and post-natal periods.

Women who may require extra support were identified early on in their journey and referred to the appropriate services such as safeguarding, smoking cessation and diabetes specialist midwives. There was also support for multiple births women, the trust told us they did not provide a teenage pregnancy service and they were referred to the family nurse partnership.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment.
Staff had received training in mental capacity and were confident in applying this in their day to day practice.

Staff were aware and followed the trust’s Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) policies. Staff demonstrated how they could access these policies through the trust intranet.

Staff understood the use of ‘Gillick competencies’ in relation to children. This is a legal ruling whereby parents cannot overrule a child’s consent when the child is judged as competent to make the decision. The understanding required for different interventions will vary considerably and therefore a child under 16 may have the capacity to consent to some interventions but not to others.

Any women who were under the care of community mental health teams were referred to the perinatal mental health team on the unit.

Staff understood and followed the trust policy and procedures for consent to care. A patient we followed up for a planned surgical procedure had the procedure explained in simple language and risks were also considered and patient were advised accordingly.
We observed staff gained consent prior to entering rooms and performing any physical interventions.

**Trust level**

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training modules from 01 April 2019 to 21 July 2019 at trust level for midwives in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>01 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>232</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>164</td>
</tr>
</tbody>
</table>

In maternity the target was met for two of the two MCA/DOLS training modules for which midwives were eligible.

The trust provided medical staffing data in the routine provider information request under the gynaecology core service. Therefore; we were unable to analyse data specifically for medical staff within the maternity core service.

We were unable to report on this and we had no assurance of how the trust was monitoring compliance with this.

**Queen Alexandra Hospital**

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training modules from 01 April 2019 to 21 July 2019 for midwives in maternity at Queen Alexandra Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>01 April 2019 to 21 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>144</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>122</td>
</tr>
</tbody>
</table>

In maternity the target was met for two of the two MCA/DOLS training modules for which midwives at Queen Alexandra Hospital were eligible.

**Is the service caring?**

**Compassionate care**

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
Staff took the time to interact with women and their families who used the service in a respectful and considerate and compassionate manner. Patients spoke positively about the way staff treated them and that the attention and support they received from staff exceeded their expectations.

Midwives ensured women’s privacy and dignity were always maintained when receiving care or sharing information. Staff used privacy curtains in the birthing pool rooms and in the shared bays when care was taking place.

We observed all staff including domestic staff and consultants knocking on doors before entering and addressing patients by their preferred name. All rooms had curtains around the beds and an extra curtain at the entrance to the room to ensure privacy and dignity was maintained.

We saw staff introducing themselves to women and explaining their roles within the department. This was in-line with NICE guideline QS15, statement 3: ‘Women are introduced to all healthcare professionals involved in their care and are made aware of the roles and responsibilities of the members of the healthcare team.’

Staff checked to ensure that women preferences and comfort were considered when providing care. Partners were also treated with respect and supported as needed. Patients told us staff treated them with care and compassion. Comments included ‘I feel my midwife listened to my worries and treated me with respect.’

**Friends and family test performance (antenatal), Portsmouth Hospitals NHS Trust**

![Graph showing Friends and family test performance (antenatal)]

From June 2018 to May 2019 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

**Friends and family test performance (birth), Portsmouth Hospitals NHS Trust**

![Graph showing Friends and family test performance (birth)]

From June 2018 to May 2019 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.
From June 2018 to May 2019 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

From June 2018 to May 2019 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: Friends and Family Test – NHS England)

The trust performed similar to other trusts for all 19 questions in the CQC maternity survey 2018.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score (0-10)</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Area</td>
<td>Question</td>
<td>Score (0-10)</td>
<td>RAG</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>6.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>8.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>4.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

**Emotional support**

Staff provided emotional support to women, families and carers to minimise their distress.

Maternity had two perinatal mental health midwives. Women were assessed for any extra care needs they may require at their ante natal booking with the community midwives. This included an assessment for post-natal anxiety and depression. Women experiencing anxiety or depression were identified and received on-going advice, assessment, psychological treatment, and onward transfer of care to other services.

Women we spoke with told us staff had offered them emotional support and reassurance during delivery of their babies and had received post -natal support. The midwives ensured that new mothers were treated with kindness and compassion, reassured women and gave them emotional support. Women told us that all the staff were very kind and supportive with breastfeeding their babies.

Women were offered, and had access to, further support and counselling if they had undergone a termination of pregnancy for foetal abnormality or for post traumatic incidents.
In line with NICE quality standard (QS115), women could access a perinatal mental health team based on the unit. Specialist support in assessing and managing mental well-being during pregnancy was available.

The trust had a team of bereavement midwives who supported women and their families following stillbirth or neonatal death. Bereaved parents would receive 1:1 care from a bereavement midwife. A local charity provided families with bereavement boxes to enable parents in keeping mementoes of their baby. The bereavement suite contained one cold cot ready for use and would provide families the opportunity to remain with their babies. The community bereavement midwives provided on-going support to families following discharge.

**Understanding and involvement of women and those close to them**

**Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment**

The continuity of carer team (Athena) promoted a normal birth and women were informed of the choice of having their baby at home or in the unit. Information was available for women and their partners to attend to gain advice and answer questions about a possible homebirth. The unit ensured women and their partners could access the same quality care and treatment and gave examples of extra support for vulnerable women and their babies.

Women were assessed for any extra care needs they may require at booking with the community midwives. This included an assessment for post-natal anxiety and depression.

Women we spoke with told us maternity staff involved them in decisions about their care and their care planning. We spoke with 11 women, partners and relatives during our inspection. They told us they were satisfied with the information and advice they had been given; leading up to and during labour; following the birth of their baby; or whilst receiving care and treatment.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served.

The maternity assessment unit (MAU) accepted referrals when complications occurred beyond 20 weeks of pregnancy and up to twenty-eight days post-partum, this included reduced foetal movements, bleeding and post-partum infections. The MAU was open 24 hours a day and seven days a week. Midwives provided triage, assessments and advice to antenatal women, and accepted referrals for investigation and/or monitoring of acute problems relating to their pregnancy.
Women were triaged by labour line, before arrival at the birth centre. Women with additional needs were flagged at the point of triage to ensure staff were aware pre-admission if any extra care needed to be implemented.

B6- was an antenatal 16 bedded ward providing care to antenatal women, 24 hours a day, seven days a week. B8- The labour/ delivery suite had 21 beds and a birthing pool. B5– Mary Rose was a midwifery led unit and co-located at the maternity unit with two birthing pools providing intrapartum and short term post-natal care to low risk women. B7- This was a 31 bedded post-natal ward supporting the care of women during the post-natal period who have previously been deemed as high risk. Staff told us they also provided some transitional care for mothers and babies needing extra support.

The induction bay was a four bedded ward supporting women who had their labour induced prior to transferring to the labour ward.

Community midwifery care and clinics were held in a variety of settings including Children’s Centres, GP surgeries, community hubs, maternity outpatients and women’s homes. Services ran between 08.30am and 5pm (seven days a week), outside of these hours an on-call service was provided.

There were two obstetric theatres within the maternity department, which were available 24 hours. Theatre one was used for elective procedures. Theatre two was the emergency obstetric theatre, there is a third theatre available if required in general theatres.

Maternity had a team of specialist continuity of carer midwives who provided care to a caseload of women. This was a 24 hour, seven days a week service for low risk women to enable choice in their place of birth. The team provided antenatal, labour care and post-natal care within the home, including support in hypnobirthing, water birthing and aromatherapy.

Antenatal breastfeeding classes were held at various venues across the local area to meet the needs of women and babies.

The trust did not carry out Chorionic villus sampling (CVS) this is a procedure for first-trimester prenatal diagnosis. The aim is to diagnose severe abnormalities that are present in the foetus. Patients were referred to another trust in Hampshire. Women were offered amniocentesis test locally. A test usually undertaken about 15 weeks in the pregnancy to screen for abnormalities in the developing foetus.

From October 2017 to March 2019 the bed occupancy levels for maternity were generally higher than the England average.

The chart below shows the occupancy levels compared to the England average over the period.
Meeting people’s individual needs

The service was inclusive and took account of patients' individual needs and preferences. Women were given a named midwife and contact number on booking, in accordance with NICE guideline QS22 statement 2.

The ‘midwifery team consisted of a range of specialist midwives, with specialisms in diabetes, HIV, bereavement, screening, substance misuse, domestic abuse and safeguarding. The trust told us the team also had a consultant midwife who provided complex care plans for women with additional needs.

The trust worked in accordance with the Safer childbirth standard which states ‘Women have the right to choose where to give birth. If a woman chooses to give birth at home or in a midwifery unit contrary to advice from midwives and obstetricians, there needs to be clear documentation of the information given’. We saw documented evidence that this standard had been met in women’s notes. Women were supported to choose where they had their babies and the risks were explained to them.

Maternity services had perinatal mental health midwives. The trust had introduced a daisy label which flagged women with mental health needs without stigmatizing and ran a daisy website which contained advice and links for other services.

Access and flow

People could access the service when they needed it and received the right care in a timely way.
Maternity services had 5,065 deliveries at the trust from January 2018 to December 2018. Maternity had a dedicated homebirth service. At the time of inspection, there were 48 home births between April 2019 to September 2019. There were 24 planned home births and 24 unplanned babies born at home (BBA). Between April 2019 and September 2019, there were 2758 total births at the trust.

Between April 2018 to March 2019 there were 166 babies were seen during this period for tongue tie assessment and infant feeding support and 121 of these babies received a frenotomy. A procedure carried out on babies for tongue tie.

There was an internal procedure for staff to follow up women who missed their appointments, they were rebooked and followed up as home visit by community midwives.

Women were discharged with contact details for the maternity service to enable them to contact the service for advice or if they experienced any issues once they had been discharged. We saw staff discussing women’s discharge planning with them on post-natal wards. For example, we saw staff giving women advice on cot death risks, including sleeping positions for babies.

The foetal anomalies obstetric sonographer worked in line with accepted authorities in this field and followed Antenatal Reproductive Choices (ARC). The service had relevant accreditation and audit in line with the National Screening Committee guidance for screening for detection of foetal anomaly. Sonographers told us 100% of women attended their 20-week ultrasound scan. Staff told us women not being seen at 20 weeks were followed up when they missed their allocated appointment.

The ultrasound reviews were undertaken by growth assessment protocol (GAP) trained midwives which meant they did not need for a Dr review. Staff completed 24 reviews, averaging 3.4 per day or 4.8 if Monday to Friday.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received

The trust had a complaints policy and staff were aware of their procedures to deal with any concerns/complaints raised at the service. Staff told us they would try and resolve any concerns raised locally and escalate to senior managers as needed.

We reviewed the trust response to five recent complaints which showed complaints were dealt with sensitively and apologies offered to women and their families. There was no evidence in the records seen that women were offered face to face meetings to review their notes and offer explanations.

We asked several staff members for examples of any learning from complaints. We were told complaints were fed back to staff; they could not give us any specific examples of changes to practice as a result of a complaint.

The trust investigated complaints and monitored their response rates to meet their KPI. Women and their families were signposted to the patient advice and liaison service (PALS). The trust’s complaints department handled all formal complaints and provided information about external
bodies such as the Ombudsman if they were not satisfied with the trust’s response. Complaints were a standard agenda items at monthly maternity clinical governance meetings.

**Trust level**

From June 2018 to May 2019 the trust received 34 complaints in relation to maternity at the trust (5% of total complaints received by the trust). The trust took an average of 46.6 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>20</td>
<td>58.8%</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>8</td>
<td>23.5%</td>
</tr>
<tr>
<td>Patient status</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Admissions / transfers / discharge procedure</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Mortuary / post mortem arrangements</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Consent to treatment</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Communication (oral)</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

From June 2018 to May 2019 there were 1,518 compliments received for maternity at Queen Alexandra Hospital (30.4% of all received trust wide).

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

**Is the service well-led?**

**Leadership**

Managers at local levels in the trust had the right skills and abilities to run a service providing support to staff and those using the service

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Staff told us they were visible and approachable in the service for women and the staff. They supported staff to develop their skills and take on more senior roles.

Maternity services had a clearly defined accountability structure. Maternity sat in the Networked Services division. The operation midwifery matron and community matron were accountable to the Deputy Director of midwifery.

Maternity staff told us the senior managers did rounds of the unit and were visible. Staff said the director of midwifery was often on the wards offering support as needed.

There were appointed clinical leads in all maternity and obstetric departments, the role of the clinical leads was spoken about positively by the staff. There was a maternity coordinator on the
shifts and had a supernumerary role to support the midwives. The maternity dashboard showed there was one occasion where the labour ward coordinator was not supernumerary.

Medical consultants and leads felt supported by the clinical director. The consultant anaesthetist lead said there was a collaborative working relationship with maternity medical leads including anaesthetists attending maternity briefings and handovers. Midwives told us consultants were visible in the unit and were supportive of staff.

**Vision and strategy**

**The maternity service worked with the trust vision. They did not have a maternity specific vision and strategy and working on developing this.**

The trust told us there was currently no maternity strategy. It was agreed, with the Chief Nurse, that a trust-wide maternity and nursing strategy would be written and was a priority for both maternity and nursing.

We asked staff about their vision for maternity and they said to be responsive, provide effective, safe care and empowering women to manage their care and increasing the birth rates in the community. The trust had developed a quality improvement plan with a due date of March 2020. This included work with care groups to embed a governance structure such as reporting, monitoring and in-built assurance processes. They were working towards the development of a sustainable workforce.

The maternity service leads told us of the work streams currently being undertaken, working with other providers across Hampshire and commissioners. The Southampton, Hampshire, Isle of Wight, Portsmouth (SHIP) and Local Maternity System programme (LMS). Some of the workstreams included working to increase the proportion of women choosing to give birth in midwifery led units or home births and supporting women to make informed choices.

**Culture**

**The service had an open culture where patients, their families and staff could raise concerns without fear. The service promoted equality and diversity in daily work, and provided opportunities for career development.**

Staff we spoke with which included midwives, maternity support workers, receptionists, senior managers and obstetricians described their culture as being supportive and respectful colleagues. Midwives and mangers told us there had been a positive culture shift and they continue to work to ‘make it the best team’.

We found a positive culture in maternity services. Staff we spoke with told us the culture had improved although this was work in progress. Midwives and support staff said there was an open culture where staff were encouraged to raise concerns and they worked well together. Staff we spoke with said they would have no hesitation in raising concerns. Staff said patient’s safety was the maternity services’ priority. Staff felt supported by their immediate line management and that they had good working relationships with other specialties in the hospital.
The trust has an appointed freedom to speak up guardian (FTSUG), supported by a number of FTSU advocates who have a key role in helping staff to raise the profile of raising concerns in their organisation and can provide confidential advice and support to staff in relation to concerns they have about patient safety. Information was available to staff in maternity on the trust’s website. Staff told us managers encouraged staff to raise concerns.

The staff said they felt part of the larger trust and senior managers were visible and supportive. There were supportive relationships amongst staff and we observed good morale and staff satisfaction.

**Governance**

*Leaders operated effective governance processes, throughout the service and with partner organisations.*

The service had standard governance and assurance meetings, performance meetings, divisional governance and assurance meetings and divisional management executive meetings which were held monthly. Sharing of information was managed through the patient safety and clinical risk committee, the serious incident forum and the mortality review processes.

We requested the minutes for the perinatal mortality and morbidity meetings, the trust told us they did not have minutes. The meetings were multi-disciplinary where cases were presented, discussed lessons learned and disseminated via email and discussed in the safety huddles. They said the basis of discussion was the presentation; therefore, minutes were not required.

We reviewed the mortality review group meeting for meeting minutes dated August 2019. There were standardised items including coroner’s reports, panel learning and feedback. The trust looked at the MBRRACE between December 2018 and June 2019 and identified themes:

- MSU for Asymptomatic bacteraemia at booking not being undertaken
- Carbon Monoxide not being written down
- Lack of documentation that a patient has had any information given about foetal movements between 16-24 weeks
- Non recording of Domestic Violence question.

Actions plans had been developed to address these shortfalls.

Records from safety huddle shared as part of lessons learnt showed that staff must ensure when they completed neonatal observations they escalate and action any abnormal result as per guidance. Staff must dial 2222 emergency call when instigating any baby requiring resuscitative intervention and not to ‘fast bleep’.

The national stillbirth rate is 4.1 per 1000 total births, the trust currently adjusted rate was 2.96 but this would increase to around 3.52. In 2018/19 there were 14 deaths which was a decrease on the previous year. From 1st April 2019 to 30th September 2019, there had been 11 still births and within the latest quarter there had been 2 very early neonatal deaths.

Maternity had a dashboard, which was used to monitor KPIs. The dashboard was reviewed at monthly networked services divisional meetings. There were also monthly managers meetings; these were attended by the maternity ward managers.

The maternity governance meeting fed into the maternity monthly quality and risk meeting. These were meetings where incident trends and near misses were discussed.
The trust had set up a maternity forum group for antenatal, intrapartum and postnatal care which was planned to start in January 2020. This had representatives from consultants, bands seven and eight midwives. There were no band six midwives and junior doctors. Some of the task and finishing groups represented on the forum included antenatal, maternal medicine, scanning, community screening, diabetes, labour line, VBAC, theatres, post-natal and bereavement.

Management of risk, issues and performance

The maternity service had some systems for identifying risks. However; these were not fully developed.

The maternity service had a risk register which was a live document and was reviewed monthly at the divisional governance meeting. Following our inspection, we requested actions which the trust had taken to mitigate maternity risks. The trust maternity risk register had identified 12 risks, which were RAG rated. This showed there were high risks (2) relating to ability to comply with updated minimum maternity data Version 2. Moderate risks included the current labour ward consultant cover not meeting the recommendations of RCOG Maternity staffing due to leave and vacancies and the lack of middle grade doctors in maternity which had a clinical and financial impact. The trust had submitted a business case and a business plan with a review date in October 2019

The trust had an audit plan which showed there was some work in progress such as looking at incidence and management of 3rd degree obstetric anal sphincter injury and manual removal of placenta, which had been completed and identified no risk. Other audits such as indication and gestation of elective caesarean section, consultant review of admitted women within 14 hours and documentation of involvement of women in care decision and deteriorating patients were RAG rated as red. These were due to be completed in June 2019 and currently showing as planning stage.

There was a lack of oversight around the overall management of incidents reported using their internal incident reporting system with an average of 120 of these were outstanding. The trust could not be assured that these risks were reviewed and addressed in a timely manner. Although there was some work planned to reduce risks these were not fully developed and embedded in practice.

The trust had set up a maternity incident reporting group to review the submitted safety learning events forms. This group would review the cases and identify emerging themes and trends in maternity; producing learning which can support service change, wider service learning and sharing findings as part of the Local Maternity System Safety Group, as well as learning on an individual basis.

The trust has plans in place specifically designed to manage different types of incident such as adverse weather, pandemic flu and fuel shortage. Ensuring these plans’ readiness was essential, and the trust tested those plans internally and with partners by conducting desk-top and other exercises.

Each year NHS England (NHSE) assessed the trust for assurance against the EPRR core standards, which set out the minimum levels of preparedness the trust should have in place. In 2018, NHSE concluded that the trust’s EPRR assurance assessment was ‘substantially compliant’ and acknowledged the extensive work undertaken in the year.

Senior midwives had access to their team’s performance dash boards so could monitor their team’s key performance indicators and key risk issues. This was used in handover and clinical
meetings. The team looked at incidents, for example, excessive blood loss, eclampsia, deep vein thrombosis and any fatality.

The service had submitted a business case to effect improvements to the pre-natal pathway. This included improvement to safety within the suspected premature rupture of membrane pathway by purchasing a diagnostic system to ensure timely and effective diagnosis. The Athena team had also sought the purchase of additional equipment and Ultrasound machines to address shortfall in continuity of care for mothers and babies.

Maternity service held twice daily safety huddles. The information from the maternity service safety huddles for the month of September showed that staff were advised of the guidelines for observations on newborn babies when mothers had taken Psychotropic medication in pregnancy.

Information management

The information systems were integrated and secure. Data and notifications were not consistently submitted to external organisations as required.

The lack of gestation period data was not followed up and the trust could not assure themselves that the data provided to Hospital Episode Statistics was of sufficient quality. The trust’s data submission to the maternity services dataset was inconsistent. It was of concern that the trust was not able to consistently submit data to external organisations, but it also may have implications for the data that the trust used internally to monitor patient’s outcomes. This could be an indicator that the availability and integrity of patient data was not always robust.

The data security and protection toolkit, a self-assessment audit completed by all NHS trusts and submitted to NHS Digital. The aim was to provide assurance annually of an organisation’s information governance practices against the national data security standards. The assessment for 2018/19 found the trust was not meeting the data security and protection standards. The trust submitted an improvement plan for the two areas where assurances could not be given. NHS Digital evaluated the action plan and changed the score to ‘standards not fully met’.

The trust used ‘white boards’ where women’s personal information was displayed including diagnoses such as women treated for sepsis, post-natal haemorrhage. This information was visible to visitors and anyone attending the maternity services. This did not promote and safeguard women and babies’ privacy and a culture where sensitive information about women were in the public domain. The trust told us that information was displayed with women’s consents.

The quality of data and information available for internal and external use was reported to be improving, as it was recognised as essential in assisting staff gaining assurance and facilitating constructive challenge. However, more work was required to ensure accurate data was available to inform discussions.

The trust IT was one of the top risks on the trust risk register. IT electronic records digitalisation was identified on the maternity risk register. The trust told us that there were limitations with their current IT systems. This included their inability to interface with other systems such as those to access safeguarding and child health records for birth registration.
Staff told us they had access to women’s record and once developed this would mean a woman’s pregnancy pathway would be recorded in one location with real-time display, allowing for recording, storage and retrieval of foetal and maternal monitoring data.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.**

The trust had in place ‘you said’, ‘we did’ which was a medium for staff to provide feedback and raise their concerns. The minutes of meeting dated August 2019 showed staff had raised questions about maternity support workers undertaking home visits for complex cases and support for band five staff.

The trust had a website where people could access information about the services they provided. There was information on the latest hospital news, charity news and the hospital’s performance. The trust had relaunched their staff network for black and minority ethnic people in January 2018. Staff told us this was a huge success and welcomed over 60 members of staff from different ethnic origins. The network had appointed a Chair and Vice Chair and developed a pathway for BAME staff development to help find solutions to overcome challenges that BAME staff face every day. The Beyond Boundary programme was launched in 2019 to support personal and professional development of BAME staff.

The BAME staff network group was part of the trust’s programme to engage staff with the workforce race equality standards (WRES) improvement plans. The WRES Survey 2018-2019 showed some positive outcomes for BAME staff, including a lack of significant difference between the percentage of BAME staff and white staff experiencing harassment, bullying or abuse from staff.

In June 2019, the trust as part of their ‘Listening into action’ programme, looked at ways to improve the work and experience of disabled staff and a number of key themes were identified. A disability network group was launched in line with workforce disability equality standards (WDES) delivery and improvements. The trust was working with this group to understand the reasons behind the WDES survey and identifying actions for improvement. Action plans included training for managers and looking at data to identify any hotspots/trend and work with divisions to develop plans for improvement via the Equality Diversity Inclusion Group and annual divisional reporting.

The trust had a Lesbian Gay, Bi sexual, Transgender (LGBT+) staff network that met quarterly to discuss any issues or concerns and support the organisation to become more inclusive. The network acted as a reference group to discuss any changes in processes or policies that may affect the LGBT+ community. The LGBT+ forum attended, and supported inclusivity events run by the trust and other organised events such as Portsmouth Pride.

The trust was committed to improve further and recognised there was more to be done. An action plan had been developed to address the issues identified in the survey. The trust took part in the better birth survey in by Wessex Voices (a collaboration between local Healthwatch and NHS England) who were asked to carry out a survey, to understand the experiences of mothers and birth partners using maternity services in the last year. More than 1200 women and their birthing partners have shared their experience of the maternity system across Southampton, Hampshire,
Isle of Wight and Portsmouth. Some of the feedback included improving breast feeding support and midwives training for tongue tie. The trust had developed midwives to undertake tongue tie procedures and had trained maternity support workers to support with breastfeeding.

Learning, continuous improvement and innovation

Leaders encouraged innovation and participation in research.

There was a focus on innovation and research in maternity. The trust had a research and development team for women and children’s services.

The trust had developed a specialist clinic in September 2019 to meet the need of high risks women such as women with multiple births. This offered women a one stop clinic and continuity in their care.

The trust had a well-developed tongue tie clinic offering advice and feeding support to women and babies. In April 2019 the tongue tie clinics were recruited to the FROSTIE study. This was a randomised controlled trial of Frenotomy Or breastfeeding Support for babies with Tongue-Tie. NPEU Clinical Trials Unit and the University of Oxford were leading the study and the infant feeding team were working with the trust research team.

The trust had signed a joint strategic plan with the university of Portsmouth and would be working together to exchange knowledge from the trust’s research projects to help improve outcomes for patients.

Outpatients

Facts and data about this service

The trust provides outpatients services from its Queen Alexandra Hospital site and at local community hospitals. The specialties covered include cardiology, dermatology, endocrinology, gastroenterology, haematology, neurology, ophthalmology, oncology, oral surgery, plastic surgery, respiratory, rheumatology and urology.

The trust provides a number of multidisciplinary ‘one stop’ clinics, where patients see a clinician along with other members of the multidisciplinary team (for example, allied health professionals).

During our inspection a team of two inspectors visited the main outpatient’s area, rheumatology, urology, cardiology, ophthalmology, audiology, ENT, surgical outpatients, haematology and oncology, trauma and orthopaedics, plastic surgery, phlebotomy, and spoke with the booking centre. The departments were open between 8.30am and 5pm although some units remained open until 6pm. Services were available Monday to Friday, with the emergency eye clinic also open on a Saturday.
We spoke with seven patients, relatives and carers. We spoke with approximately 40 members of staff including managers, nursing staff of all grades, doctors, therapists, reception and medical records staff, and healthcare assistants. We saw care in outpatient clinics and looked at four sets of patient records. We received comments from staff, patients and the public directly.

In addition, we reviewed national data and performance information about the trust and read a range of policies, procedures and other documents relating to the operation of the outpatient department.

(Source: Routine Provider Information Request AC1 - Acute context)

**Total number of first and follow up appointments compared to England**

The trust had 822,461 first and follow up outpatient appointments from March 2018 to February 2019. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

**Number of appointments by site**

The following table shows the number of outpatient appointments by site and trust compared with England, from March 2018 to February 2019.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Medical and nursing staff told us that they were responsible for completing their own mandatory training. They told us they could access training on-line and face to face. However, we were told training for medical staff was lower than the trust target because staff were unable to access face to face training in clinical time.

Mandatory training was comprehensive and met the needs of patients and staff. Staff attended training in areas that included dementia awareness, mental capacity, infection control, manual handling and basic life support. Staff also attended training that related to their specific role including safeguarding children and paediatric life support.
Senior staff monitored compliance to mandatory training and alerted staff when they needed to update their training. Staff were told if their training was due and managers kept electronic records to monitor this.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses from 1 April 2019 to 21 July 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>189</td>
<td>189</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>189</td>
<td>189</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>188</td>
<td>189</td>
<td>99.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>188</td>
<td>189</td>
<td>99.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>187</td>
<td>189</td>
<td>98.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>187</td>
<td>189</td>
<td>98.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>186</td>
<td>189</td>
<td>98.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>180</td>
<td>187</td>
<td>96.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>175</td>
<td>187</td>
<td>93.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>171</td>
<td>187</td>
<td>91.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>171</td>
<td>187</td>
<td>91.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>165</td>
<td>187</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>134</td>
<td>157</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>148</td>
<td>187</td>
<td>79.1%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for 13 of the 14 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from 1 April 2019 to 21 July 2019 at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In outpatients the 85% target was met for seven of the 13 mandatory training modules for which medical staff were eligible.

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific to their role on how to recognise and report abuse. Staff had training in adult safeguarding and those who worked in areas where children visited also had training in children’s safeguarding. Staff were aware of their responsibility to act and raise concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a trust wide safeguarding policy that was accessible to all staff. Staff could access advice and support using the trust intranet and would discuss concerns with the nurse in charge. One member of staff gave an example of having to intervene when two patients with mental health issues were arguing. They were calmed down by the staff member who spoke to the nurse in charge, completed a safeguarding referral and an incident form. Staff told us that they would contact the trust safeguarding lead if they needed additional advice. However, the post was vacant at the time of our inspection and staff were unsure of the named person covering.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was a process to alert other agencies if a child attended for unscheduled care for example at the emergency eye clinic. If a child attended the clinic, staff would check the online summary care record for additional information and their attendance for unscheduled care was flagged on the patient information system. Staff told us that in the last six months they had one patient who was not brought to an appointment and another where they raised concerns of neglect. Staff explained how they alerted other services. The department also displayed a leaflet that told parents and carers what happened if a child was not brought in for an appointment and how the staff would contact the GP to inform them of this.

We saw posters that told patients how to ask for a chaperone. In some clinics a nurse or support worker was available in the room to support the clinician and would also act as a chaperone.

Staff followed safe procedures for children visiting the department. Staff told us that the paediatric outpatient department saw the most children. However, there were clinics that children attended with families or were seen by a paediatric doctor in the adult clinics. Staff told us all staff working with children had safeguarding training.

The trust took part in audits to monitor the safeguarding of children. The trust used an audit tool with three other local government and NHS organisations. The trust measured safeguarding
against 12 standards and rated itself against potential scores of outstanding, good, requires improvement, inadequate or not applicable. These included effective inter-agency working for early help, staff responsibilities and competencies, training on safeguarding and promoting the welfare of children and managing allegations. Once the trust had completed the audit it produced an action plan for areas that needed improvement. The action plan for the last audit in 2018-2019 included further development of the safeguarding operational lead role and running a safeguarding conference for staff.

### Safeguarding training completion rates

The trust set a target 85% for completion of safeguarding training.

#### Trust level

A breakdown of compliance for safeguarding training courses from 1 April 2019 to 21 July 2019 at trust level for qualified nursing staff in outpatients is shown below:

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>trained</td>
<td>staff</td>
<td>rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>188</td>
<td>189</td>
<td>99.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>156</td>
<td>157</td>
<td>99.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>187</td>
<td>189</td>
<td>98.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Basic Awareness</td>
<td>187</td>
<td>189</td>
<td>98.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>165</td>
<td>187</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>29</td>
<td>34</td>
<td>85.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>158</td>
<td>187</td>
<td>84.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for six of the seven safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from 1 April 2019 to 21 July 2019 at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>trained</td>
<td>staff</td>
<td>rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Basic Awareness</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>8</td>
<td>13</td>
<td>61.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>8</td>
<td>13</td>
<td>61.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
In outpatients the 85% target was met for four of the seven safeguarding training modules for which medical staff were eligible.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The outpatient departments and clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff told us that cleaning was usually carried out in the evenings. One senior nurse told us the chairs in their clinic were easily cleaned and pressure washed periodically.

Cleaning records were up-to-date and showed all areas were cleaned regularly. The infection control team completed an audit four times a year for all clinic areas. After this inspection we asked for information from the trust’s infection control team on environmental infection control audits. The results of the September 2019 infection control audit for the emergency eye clinic showed chairs were noted to be damaged and an action plan was put in place to repair or replace them. On this inspection, we did not see any damaged chairs in the waiting area. However, the emergency eye clinic waiting area was carpeted. This was vacuumed but could not be deep cleaned. Staff told us that this had been raised with managers but they were awaiting the outcome of other department refurbishments. We noted that the carpet was recorded as acceptable on the last audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbows in line with the trust policy to reduce the spread of infection. Hand sanitizer was available in all departments and some departments had systems where sanitiser was applied automatically as the handle was pulled to open the door.

Staff showed us a monthly hand hygiene audit that was completed for all staff in the clinic including nurses, health care support workers, doctors and students. The results were sent to the infection control team who collated the results across the outpatient departments. We saw data from September 2019 reporting a compliance of over 95% in line with trust targets.

Blood spillage kits were available in all clinical areas. Staff told us how they would manage if a staff member or patient was injured by a needle. This followed the trust policy of immediate first aid, contacting the occupational health department for further treatment and reporting the incident on the electronic data base for investigation.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw up to date ‘I am clean’ stickers on equipment this meant staff knew what items were clean and ready for use. Equipment was visibly clean. Staff told us that they would clean treatment rooms between use. In the ears, nose and throat department the door of each room would have an ‘I am clean’ sticker displayed so staff knew all the equipment and the room were clean.
Endoscopes are used to examine the inside of the body. An endoscope is a long, thin, flexible tube with a light and camera at one end. Pictures of the inside of the body are shown on a screen to be reviewed. We saw a member of staff in surgical outpatients handling clean endoscopes following decontamination by the hospital sterilisation and decontamination unit (HSDU). The staff member had received training from HSDU and there was a system for the safe flow of clean and dirty equipment through the department. There was no cross contamination of clean and dirty equipment and the process had been agreed with HSDU.

We saw another staff member in the ear, nose and throat clinic handling used endoscopes. There was an established process for the manual cleaning and tracing of used equipment. The cleaning products used followed manufacturers guidance and endoscopes were tracked throughout the process. Green and red plastic covers were used to identify clean and dirty equipment trays and were kept separately. We saw that PPE was worn throughout the process and gloves were changed at each stage to avoid cross contamination. Staff showed us trays of sterile instruments, for example items to examine ears, and how this was removed after use and taken for sterilisation at the end of the day.

Environment and equipment

The design, maintenance and use of most facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

Facilities and premises were appropriate for the services being delivered. On our last inspection, we found that some waiting areas were cramped for the number of patients visiting the clinics. On this inspection we found that some clinics in the newer part of the hospital were light and airy while others in the older part were darker and more crowded when busy.

Most out-patient departments had adequate seating areas. However, the service did not always have suitable premises. Outpatient services were based in several locations throughout the hospital and some were based on other sites in the local area. At our last inspection, some outpatient waiting areas in the eye department and renal outpatients were not suitable for the volume of patients attending clinics. We saw many clinics were very busy in the mornings and the eye clinic waiting area was crowded with patients and relatives having to stand. However, staff taking blood tests in the phlebotomy clinic told us that if possible, they would try to find room in another clinic and take patients and a trolley with them.

At this inspection, we saw that some waiting areas had chairs of different heights. This meant patients who needed a higher chair for comfort or ease of standing up were able to access one. Staff arranged chairs and walkways between seats to accommodate wheelchairs in some clinics. We saw chairs and treatment couches suitable for bariatric patients.

The eye clinic was arranged to allow patients to check in at the reception desk and wait to be called through for vision testing. We saw patients sitting in a corridor having eye drops before they were taken to the next waiting room to see the consultant team. The vision lanes in the department, where patients had their visual acuity tested, were in between the waiting areas and patients were tested behind curtains. The patients sitting in the corridor for eye drops were able to overlook the vision lanes and vice versa. This reduced the privacy available for both. In the emergency eye clinic, patients were seen behind a curtain for triage. However, nurses were in the
same area taking telephone calls and this reduced privacy for patients in the room and confidentiality of patients on the telephone.

We were shown sound proofed assessment rooms in the audiology department with high steps into the room. Staff told us that this was part of the original design from the 1970’s when sound proofed flooring was required. We saw large signs on all doors warning patients to mind the step and staff would also tell patients as they entered the room. However, this meant that patients with limited mobility or using wheelchairs could not be treated in these rooms. Staff told us that they could book appointments at other locations but that this not always possible until after the patient had attended for the first appointment. Staff were not always aware that the patient had limited mobility until they arrived, this was because the booking was made centrally and not in the department. Managers were to discuss changing the booking process so new patients were booked by the department and therefore avoid delays.

Patients told us that there were plenty of toilets available. We saw accessible toilets throughout the hospital. However, some in outpatient departments required refurbishment and painting.

We saw separate children’s waiting areas in clinics that were mainly used for adults. This meant children and adults did not have to wait in the same area. We saw that the children’s areas had toys and children’s posters on the walls.

Staff carried out safety checks of specialist equipment. Staff reported broken equipment to the nurse in charge or the estates team. Four out of 15 items of equipment we checked had not been serviced within the past 12 months. The four pieces of equipment were located in the oncology outpatients department. We escalated this to the matron during the inspection. However, we did not have the opportunity to return and check this had been resolved.

The service had enough suitable equipment to help them to safely care for patients. We saw resuscitation trollies in most departments. Although some were shared between smaller clinics, they were located within easy reach of all staff. Trollies were checked every day and we saw the evidence of this. We were told by staff that the paperwork was also checked regularly by the resuscitation team and any issues were raised with the senior member of staff in the clinic. In some clinics, staff were allocated daily or weekly tasks. These included checking the equipment on the resuscitation trolley and observing and recording hand hygiene audits. In one department, there was an information board that reported to staff the number of sterilisation machines available that day. This meant staff were aware before clinic if there was likely to be enough equipment available or a delay in getting it.

Staff disposed of clinical waste safely. Sharps containers and waste bags were collected from a shared disposal cupboard outside the departments. These were locked with a secure keypad.

We saw that there was limited storage for substances that could be hazardous to health. Staff told us they did not keep many of these substances in the department. We requested examples of risk assessments for the storage and use of cleaning fluids and saw that the solution should be stored in a locked cupboard when not in use. We saw that doors to dirty utility rooms were not fitted with locks. Cupboards which stored cleaning solution tablets were unlocked and we saw three rooms where bottles of cleaning fluids were stored on draining boards. This was not in line with the trust wide risk assessment for the use of this solution.

Curtains in the clinics were not routinely cleaned. Staff told us that they would check them regularly and request cleaning if there were visible marks or they were aware of a patient with an infection using the room. The infection control team and department staff were responsible for
reviewing the environment and the facilities to provide a safe and clean environment for patient care. Staff told us that the infection control team were aware that there was no routine replacement programme for curtains in outpatient departments although there was on the in-patient wards. There was no statement about the cleaning of curtains in the trust infection prevention and control policy. We saw audit data that recorded cleaning in departments but did not record curtain cleaning.

We saw fire extinguishers that were in date and secured to the walls. We saw signs directing visitors and staff to fire exits.

Staff told us that information systems were sometimes challenging to use. The booking centre staff told us that the telephone system was reliable. However, staff told us that the computer systems could be slow at times if there were lots of staff trying to use it at once.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. Some departments had developed guidance for patients on when and how to seek help with symptom control.

Staff responded promptly to any sudden deterioration in a patient’s health. Staff told us that if a patient became unwell they would call for help. Staff told us that they were able to call 2222 to access the resuscitation team in an emergency in line with the trust policy. A member of the team would collect the resuscitation trolley from the nearest location. All staff we spoke to knew where their closest trolley was kept. Staff also told us where they could find an inflatable mat that was used to help patients up from the floor after a fall.

Basic life support was part of the trust’s mandatory training programme. Compliance to basic life support training as of July 2019, was 79.1% for nursing staff and 84.6% for medical staff. The trust target was 85%.

Staff told us about helplines where patients could call into clinics for advice and support. Staff told us that some patients would be invited to a rapid access appointment if a medical intervention was required urgently, for example to unblock a catheter. Other helplines were in clinics where staff could respond to questions by email or call patients back. One matron told us that in Rheumatology they had over 800 calls a month into the helpline. This was managed by one nurse who responded to messages three times a day. We were told that the success of this service meant that following an audit of the themes of calls, the trust was planning to fund a clinical psychologist to support the most anxious callers.

Staff knew about and dealt with any specific risk issues. Staff showed us patient information cards that were given to patients who had started chemotherapy. These cards gave patients information on who to contact if they developed a high temperature, flu like symptoms, a sore mouth, infections, or became short of breath. Patients were always advised to carry the card and contact the department if they felt unwell. Reception staff in Oncology and staff in the Macmillan centre told us that they could contact the oncology clinic if visitors became unwell. Staff in the emergency eye clinic told us they had instigated a sepsis pathway to identify unwell patients who attended for urgent care.

On the last inspection, National Safety Standards for Invasive Procedures (NatSSIPs) were embedded in the organisation. NatSSIPs provide a framework for Local Safety Standards for Invasive Procedures (LocSSIPs) and dedicated LocSSIP checklists were used for invasive
procedures like scopes and minor procedures. On this inspection, we did not see evidence of their use in the departments we visited. We spoke to staff in plastics and surgical outpatients, where invasive procedures took place, and they were not able to describe a LocSSIP and its use in their department.

**Nurse staffing**

The service had staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers told us that there were teams that were short staffed and each department addressed this differently. Staff told us in one clinic they were able to offer honorary, three-month, unpaid contracts for staff undergoing privately funded phlebotomy training in order to achieve the skills and competency for a post. The manager told us they had been able to offer this for the last three years and had recruited permanent staff as a result. We spoke to senior nurses who employ new graduate nurses as additional staff. This was so that they could become familiar with all the clinics in departments, especially where multiple specialities are based, before they start working independently.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Senior clinic staff told us that in many areas staffing was a challenge, but they would look at the staff and grades they had in clinic and share staff with other areas if required. For example, staff working in the blood testing clinic would be asked to support the team taking blood on the wards. Staff told us that in some departments they manage sickness and leave between them. Some clinic staffing levels were measured against similar services to allow managers to establish appropriate staffing levels. Staff told us they used this information when requesting extra staffing.

Managers could adjust staffing levels according to the needs of patients. We spoke to one senior sister who told us that they based the skill mix of the team on the needs of the clinics. Another manager told us they had been training band 2 and band 3 nursing staff to support and run clinics alongside qualified nursing staff. This meant they were able to train staff to fill roles within their current workforce.

**Trust level**

The table below shows a summary of the nursing staffing metrics in outpatients at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
</table>

20190416 900885 Post-inspection Evidence appendix template v4
Nurse staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and agency use.

### Outpatients annual staffing metrics

**November 2018 to October 2019**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>304.6</td>
<td>4%</td>
<td>9%</td>
<td>4.9%</td>
<td>5,906 (49%)</td>
<td>1,330 (11%)</td>
<td>4,856 (40%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>171.6</td>
<td>4%</td>
<td>8%</td>
<td>4.0%</td>
<td>5,906 (49%)</td>
<td>1,330 (11%)</td>
<td>4,856 (40%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Sickness rates

The service had low and reducing sickness rates. Staff told us that they would provide cover for sickness within the team. Some clinics reported incidents of staff being on long term sickness but did not report that staff sickness was a significant risk as they managed it within the service.
Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from October 2018 to February 2019.

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

Bank staff usage
The service reported a reducing rate in employing bank and agency nurses to cover clinics. Staff told us they tried to cover the shifts themselves by working extra bank hours. Staff told us that if possible, they used bank staff to manage staffing for clinics or would liaise with other clinics to help cover areas of need.

Managers limited their use of bank and agency staff and requested staff familiar with the service. In some areas, staff told us their skills were specialised and it was not easy to use bank staff if they did not have the skills or experience to work in the team.

Managers made sure all bank and agency staff had a full induction and understood the service. We were shown completed local induction for bank and agency staff. Managers told us that locums in some clinics would only be allowed to work at the main hospital site and would not work alone in the off-site clinics. In audiology, locum staff completed a two-day induction and competencies based on accreditation schemes and trust competencies. They then took follow-up appointments to reduce waiting lists.
Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives shows a shift from December 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Queen Alexandra Hospital

The table below shows a summary of the nursing staffing metrics in outpatients at Queen Alexandra Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>231.8</td>
<td>5%</td>
<td>8%</td>
<td>4.5%</td>
<td>4,881 (59%)</td>
<td>663 (8%)</td>
<td>2,795 (34%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>132.5</td>
<td>6%</td>
<td>10%</td>
<td>4.3%</td>
<td>4,881 (59%)</td>
<td>663 (8%)</td>
<td>2,795 (34%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within outpatients at Queen Alexandra Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency use.

Vacancy rates

The service reported an increase in vacancy rates in May 2019. Staff told us that there were vacancies in the outpatient department and that this was due to difficulty recruiting staff in a number of areas. We met students who were training and staff members who were being trained to take other roles in the hospital. We spoke to managers who reported that due to fewer courses being offered at universities to train some allied health professionals there were less newly qualified staff applying for posts nationally. This impacted on the service being able to develop their own staff from junior to senior posts. Some services had to employ locums or review the skill mix of staff to continue providing a service.
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from January 2019 to May 2019.

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

Sickness rates

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from October 2018 to February 2019.

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

Bank staff usage
Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives shows a shift from December 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

Medical staffing

Trust level

The table below shows a summary of the medical staffing metrics in outpatients at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>298.7</td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td>44 (23%)</td>
<td>0 (0%)</td>
<td>147 (77%)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>12.4</td>
<td>3%</td>
<td>8%</td>
<td>0.1%</td>
<td>44 (23%)</td>
<td>0 (0%)</td>
<td>147 (77%)</td>
</tr>
</tbody>
</table>

Medical staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use and agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)
Trust level

The table below shows a summary of the allied health professional staffing metrics in outpatients at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>8%</td>
<td>12%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>298.7</td>
<td>4%</td>
<td>9%</td>
<td>4.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>2.5</td>
<td>3%</td>
<td>0%</td>
<td>2.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Allied health professional staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use and agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Records

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

Patient notes were comprehensive, and all staff could access them easily. The trust was moving from paper records to an electronic patient records system. At the time of our inspection, some clinics were paperless with patient records held electronically. We saw some clinics that were partially using paper notes where the system did not allow for operation notes to be electronic. We saw clinics where clinicians from other hospitals still needed full paper patient records. Staff told us that they were all aware of the need to move entirely to electronic records and all staff we spoke to were welcoming of this change.

Nursing and reception staff reported that patient notes were usually available for clinics. In clinics where there were no paper notes, staff told us that sheets were available for the clinician to write on before either dictating a letter or documenting the appointment on the electronic system. Staff told us that the medical secretaries would transcribe letters and scan operation notes onto the system. They told us that any paper not needed was destroyed as confidential waste. Staff told us that paper notes were transferred back to the medical records library. We saw four sets of patient records, electronic and on paper. They were detailed and clear to read. Staff showed us the electronic system included the patients’ appointments across all clinics they attended, the date of the next appointment, scanned documents and letters. Staff told us there was a trust information governance audit every three months to check compliance. After the inspection we saw five audits. All five were compliant with the trust compliance checklist.
We were told that the electronic patient check in system recorded the patient’s attendance. Staff showed us how they could audit attendances for every speciality clinic on the system but there was no option within the electronic records to record if a patient did not attend (DNA). We were told that this had been raised with the trust information technology department.

Staff used a separate electronic system to share test results. Staff said that this improved the sharing of information between clinicians and other areas of the hospital and made clinic run smoothly.

Records were stored securely. On our last inspection, we saw that patient records were not held securely to protect confidential information. On this inspection, we saw boxes of paper notes in clinics that were not using electronic notes. These were kept behind reception desks and then locked away at the end of the clinic to await collection from the medical records staff. Boxes were tagged, labelled and the rooms where the boxes were left were secured by key pads. In clinics, notes were held securely either on the electronic system or on trolleys with nursing staff outside clinic rooms. In some areas, paper records were covered by a laminated sheet and computer screens were turned from view or covered with a sheet of card to protect patient confidential information. We observed a member of staff being challenged as they were in a clinic area without a trust identification badge.

Information governance was part of the trust’s mandatory training programme. In the last 12 months up to October 2019, 121 of staff eligible in the outpatient department, 98.4% had completed the training which was above the trust’s target of 95%.

**Medicines**

*The service used systems and processes to safely prescribe, administer, record and store medicines.*

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. On our last inspection, daily fridge temperature checks were not always recorded and prescription stationery was not always audited. On this inspection, we were shown locked fridges for medicines that needed refrigeration with completed daily fridge temperature checks. Medicines and intravenous medications were stored appropriately in locked cupboards, fridges and treatment rooms. We saw completed audits of medicines that showed that stock was in date and the amount stored matched the paper record. Staff told us that the pharmacy team and the sister audited medicines monthly. We saw written evidence of this. We reviewed a random sample of medicines and consumables such as dressings and syringes, in six clinics. We found that they were all in date. Staff told us that where the expiry date was due they had ordered replacement stock.

We saw oxygen cylinders and all but one were in date. They were stored safely in treatment rooms and on resuscitation trolleys. We reported the one oxygen cylinder which was out of date to the Matron in Orthopaedics and this was removed immediately.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Staff showed us external pharmacy prescription (FB10) forms that were always kept locked away. The blank forms were recorded in number order on an audit form and the prescriber and nurse both signed to confirm when a prescription was filled in and given to a patient. This prevented the forms being issued without medical agreement. We were shown documentation of this in several departments. Prescription forms completed by medical staff and given to patients that could only be used at the hospital pharmacy were locked away at the end of each clinic. Staff told us that in
some clinics nurse prescribers were able to issue prescriptions by using shared agreements with GPs.

In the eye clinic, we saw files with completed competencies for issuing medicines to patients under patient group directives (PGD). A PGD is a document agreed by a pharmacist and signed by a doctor. A PGD gives the nurse permission to supply and/or administer specific medicines to an agreed group of patients using their own assessment of the patient needs. The nurse did not have to request an individual prescription from a doctor each time. We saw that these had been signed and authorised correctly. However, some had been completed but the version date on the paperwork for three medicines had expired in June 2019. This meant that there was no assurance that the staff were using the most recent paperwork for three medicines. We raised this with the nurse in charge and the pharmacy team were informed. The Divisional Leadership told us that they had been made aware and were assured the paperwork would be updated as a result.

We saw intravenous (IV) treatments being given in the rheumatology department. Staff told us that they followed the pathway for treatment that related to each medicine used.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff told us that safety alerts were posted on the home page of the trust intranet. All staff would see them when logging onto the system. Other staff told us that the alerts were emailed to managers who shared them with the staff at team meetings or by email.

Although the resuscitation trollies were not tamper proof and medicines were placed in tamper evident boxes on the bottom shelf of the trolley, this was in line with the trust policy for the storage of medicines on the trolley.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses within the clinical area. Managers investigated incidents and shared lessons learned with the team. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff told us they used the electronic incident reporting system to report incidents and near misses. Staff knew what incidents to report and how to report them but did not always report them if they occurred outside the clinic area. We spoke to staff who had responded to incidents in the public areas of the hospital and had not reported the incident on the system. We were told by staff that following an incident the team would discuss it and have a de-briefing session.

Staff gave us examples of how to report an incident. During this inspection, we were made aware of a staff member being injured in a fall in a clinical area. The staff told us that they had reported it to the nurse in charge and recorded it on the system.

Staff understood the duty of candour. Some staff were aware of the concept and had not needed to act on it. Others understood the process but not the term. Staff told us they were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of most incidents if they were directly involved or through team meetings. Staff reported that senior staff would discuss the feedback with them. However, staff told us while feedback had improved not all incidents were discussed with staff.
Managers debriefed and supported staff after any serious incident. Staff told us that they would be given the opportunity to discuss concerns following an incident. We were told by staff that after a staff member was injured in a fall in clinic, the team were made aware of the cause and the initial outcome.

**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 August 2018 to July 2019, the trust reported no never events for outpatients.

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

Managers shared learning with their staff about cases of harm to patients. After the last inspection, the trust set up an Ophthalmology Clinical Harm Review group in August 2018. In October 2017, the trust had identified three cases of moderate harm to patients, as a result of delays in making their follow up appointments. The group met every two weeks until Jan 2019 and consisted of senior staff and clinicians from the trust and two external experts. The team identified that the contributing factors included a high volume of patients requiring appointments and no formal process for managing the waiting list for patients who had appointments cancelled. An action plan was made to include improved trust oversight of waiting lists, posts to support the failsafe processes, training and recruitment of admin staff. Staff told us that there was now a standard operating procedure for managing cancellation of appointments.

**Breakdown of serious incidents reported to STEIS**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from August 2018 to July 2019. A breakdown of incidents by incident type are below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>4</td>
<td>50.0%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>2</td>
<td>25.0%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*(Source: Strategic Executive Information System (STEIS))*
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies and protocols we reviewed, were in date and available on the hospital’s intranet.

In the rheumatology clinic staff managing the patient helpline responded to 97% within 48 hours, 94% within 24 hours and 81% within one hour. We were shown the latest audit data by the manager who was proud to tell us that the service was in line with NICE standards for ongoing educational and self-management for patients accessing Rheumatology services.

The oncology clinic issued patients with information cards that alerted them to potential infection. This followed the NICE guideline for Neutropenic sepsis: prevention and management in people with cancer.

The trust medicines management policy ensured that staff administering intravenous medicines and fluids were compliant with the NICE guidelines for healthcare professionals’ competencies in hospitals. Staff in the rheumatology outpatient department had been trained using standard trust competencies and were able to contact the trust IV team if they needed assistance.

Some departments took part in national clinical audits. The cardiology team told us that they took part in the ‘Getting it right first time’ national review programme and were praised on the cohesiveness and effectiveness of the service.

Nutrition and hydration

Staff made sure patients had access to food and drink while waiting in clinics.

Staff told us that they would direct patients to the hospital shops, cafes and restaurants if clinics were running late. We saw water coolers in waiting areas for patient use.

Patients had access to nutritional advice and a nutritional nurse specialist. Staff were able to refer patients to the Nutrition and Dietetic team based within the hospital and in the community.

Pain relief

Staff accessed pain relief within outpatient clinics in line with individual needs.

Staff told us that patients were advised on pain relief during appointments if it was required. There was a separate pain clinic within the outpatient service.

Patient outcomes
Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Services had been accredited under several accreditation schemes.

Outcomes for patients were positive, consistent and met expectations. We saw clinics where staff had completed local audits and developed services to improve patient outcomes. Staff in the plaster room told us that they had seen patients returning to clinic in plaster casts with sore skin or complaining of discomfort. To reduce these concerns staff were looking for patients on the wards every day to check their plasters. The staff told us that patients were given information on how to look after their plaster, how to prevent pressure sores and how to reduce the risk of developing blood clots. This was recorded in the patient records for both inpatients and outpatients and checked at the next appointment. Staff told us that patients were often able to see the same staff member at appointments.

Clinicians used information from the audits to improve care and treatment and staff used the results to improve patients' outcomes. Staff told us that they were involved with national clinical societies and feedback to departments on shared decision making tools and national audit reports, for example the early involvement of specialist teams with heart failure patients.

Services participated in a number of accreditation schemes. The oncology service had been awarded a Macmillan Quality Environment Mark (MQEM) for a further three years. The Macmillan Quality Environment Mark is a quality framework used to assess whether cancer care environments meet the standards required by people living with cancer. The department had to meet standards for accessibility, privacy and dignity and listening and supporting patients and families. The award is valid for three years and can then be applied for again. We were told by staff in audiology that they were proud that the service had been assessed and awarded an Improving Quality in Physiological Services (IQIP) accreditation for paediatric services and were to continue accreditation for the adult assessment and rehabilitation service. IQIPS was a professional accreditation scheme that aimed to improve services, care and safety for patients and encouraged the sharing of best practice.

Follow-up to new rate

From 01 March 2018 to 28 February 2019 the follow up to new rate at both Queen Alexandra Hospital and the trust overall was lower than the England average.
Follow-up to new rate, Portsmouth Hospitals NHS Trust and Queen Alexandra Hospital

![Graph](image)

(Source: Hospital Episode Statistics)

Competent staff

The service made sure staff were competent for their roles. Managers had a system to appraise staff’s work performance however, not all staff had a recent appraisal recorded. They held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We saw competencies for staff that were completed every two years to keep and update their skills. Staff who also worked in the paediatric clinics had paediatric competencies. There were clinical nurse specialists in most clinics and link nurses for other specialities who had additional training, such as dementia, nutritional and rheumatology nurse specialists, cancer link nurses and heart failure specialist nurses. Some of these specialist nurses worked in other teams but were available for advice when requested.

Managers gave all new staff a full induction tailored to their role before they started work. All staff received a trust induction. Staff in clinics showed us local competency folders for new permanent staff members. Senior staff told us that they would keep new staff members in one place until they were ready to work in other areas of the clinic. We spoke to staff who were new to the trust. They told us that they were very supported and given time to settle into their departments. They also told us that they felt valued and could get advice from other staff if they needed it.

Managers supported nursing, medical and administrative staff to develop through yearly, constructive appraisals of their work. We spoke to different grades of staff who told us that they had yearly appraisals and were able to raise concerns. We were told that previously medical staff reported that they had poor appraisals, career development and progression. The trust reported that this had improved and that doctors who had been at the trust before were now returning as appraisals and development opportunities had improved. All booking centre staff had appraisals and had access to senior staff when they worked at external clinics.

Managers told us that if they identified poor staff performance they would support staff to improve. One sister told us that a student had been struggling on a previous placement and was transferred...
to another department where they were improving their performance with the correct support. Other managers told us they would discuss issues at appraisal or as they became clear.

The clinical educators supported the learning and development needs of staff. Some staff told us they received support from their managers to mentor students. Students reported they were supported by the team in their training.

Staff told us they had appraisals. However, trust information showed us that four of five staff groups did not meet the trust target of 85%.

**Appraisal rates**

From June 2018 to May 2019, 82.5% of staff within outpatients at the trust received an appraisal compared to a trust target of 85%.

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2018 to May 2019</th>
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<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
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<tr>
<td>Medical and Dental</td>
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<tr>
<td>Nursing and Midwifery Registered</td>
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<tr>
<td>Additional Clinical Services</td>
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<tr>
<td>Administrative and Clerical</td>
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</tr>
<tr>
<td>Allied Health Professionals</td>
<td>2</td>
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</tbody>
</table>

**Queen Alexandra Hospital**

<table>
<thead>
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<tr>
<td>Administrative and Clerical</td>
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<tr>
<td>Medical and Dental</td>
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<tr>
<td>Additional Clinical Services</td>
<td>72</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>110</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>2</td>
</tr>
</tbody>
</table>

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

Managers made sure staff attended team meetings or had access to full notes when they could not attend. On our last inspection, we noted that some departments did not have regular team meetings. On this inspection, that remained the same in some departments. However, we were told that where meetings were not practical as staff were spread out over many sites, managers had trialled other methods. We were told about ‘Breakfast with Matron’ meetings before clinic opened, team meetings that were rotated between sites or clinics on a monthly rota and ad hoc meetings where managers would seek staff out to share information. We were told by staff that if
they were unable to attend, minutes would be emailed or displayed in offices. The booking centre and administration staff that work on external sites were visited by a senior member of staff every month. These teams would be sent team updates electronically to ensure they were always kept informed of issues and developments.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they were supported in training for other roles. One staff member told us they were being supported to train as a nurse while in their current post. In the fracture clinic, we were told by staff that two other technicians had trained as nurses supported by the trust. However, staff told us that because of development opportunities elsewhere in the trust they sometimes lost staff and were unable to cover the vacancy.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that they would make requests for extra training throughout the year and not only during appraisals. Staff reported some training was not necessarily agreed but they felt able to discuss it.

Managers made sure staff received any specialist training for their role. We were told that in some clinics, staff who worked elsewhere in the trust would receive training alongside regular clinic staff. In the emergency eye clinic, a trainee GP worked with the team of consultants to develop their skills. Staff told us that they were able to attend in-house training and that this time was available as part of their working day. However, other staff members told us it was often difficult to attend training that was not mandatory if clinics were busy.

All staff in the trust were offered an induction to the Macmillan centre support service as additional training. The Macmillan centre team supported carers and patients with oncology and life limiting conditions. Staff told us that they could contact the team for advice for patients from other clinics and inpatient wards.

Staff told us that the service used volunteers to support patients. We saw volunteers in many departments. Staff told us that they were often past patients or relatives who had used the service themselves. Volunteers were given an induction. Staff told us they would ask volunteers to sit with patients who were alone in the department or could go with them to other departments, for example x-ray. Other services had volunteers who would stock up patient information leaflets and run fundraising for the departments. One group of volunteers had been nominated for the Pride of Portsmouth award for 2019 for their work in Rheumatology where they supported patients who attended clinic and ran fundraising events for the service.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Some departments held regular and effective multidisciplinary meetings to discuss patients and improve their care. Cardiologists told us they offered a service where GPs and community nursing teams were able to support patients in the community with guidance from the hospital team. This reduced the need for patients to attend appointments at the hospital. Staff told us that there were weekly meetings with the multidisciplinary team including doctors, heart failure specialist nurses and palliative care teams to discuss individual patient care plans and developments for support of this patient group.
Staff in other departments told us that while they worked closely with other healthcare professionals and support services, they did not have formal meetings. On occasion the multidisciplinary team would meet as part of a team meeting in clinic but not specifically to discuss individual patients. The trust provided a number of multidisciplinary ‘one stop’ clinics, where patients saw a clinician along with other members of the multidisciplinary team (for example, allied health professionals). Patients in plastics outpatients saw nurses, consultants and hand therapists at one appointment and in cardiology patients were seen for diagnostic tests and then by the consultant in one appointment. Doctors told us they would then share care with GPs to avoid additional hospital appointments. We saw white boards in the orthopaedic clinic where the team met weekly to discuss working together to meet the trust values. This encouraged team working and support between staff groups.

Seven-day services

Some services were available six days a week to support timely patient care.

Most clinics in the outpatient department were open from approximately 8.30am until 5pm. Blood testing was offered during longer hours from 7.30am until 5.30pm Monday to Thursday, and from 7.30am until 5pm on Fridays. Staff in some clinics told us that they were planning to run extra clinics on a Saturday from November to reduce the number of patients on the waiting list for follow up appointments. The emergency eye clinic was also open on a Saturday morning. As the main eye clinic was closed, nursing staff or a health care support worker would go with the doctor and patient if they needed to use the equipment in the outpatient department. Staff told us this was to maintain safety and prevent staff working alone.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw patient information displayed in all clinics. This included guiding patients and carers to support services, information on conditions, smoking cessation and drink awareness. We saw clinics that had seasonal displays, for example to promote flu season. Staff told us that there were similar displays at other times of the year.

Staff assessed each patient’s health at every appointment and provided support for any individual needs to live a healthier lifestyle. The oncology team worked closely with the Macmillan support team. Staff told us that they would signpost patients and families for support including wig fitting, complimentary therapies and education sessions on the treatment they might have. Patients could access volunteers from Citizens Advice and counselling services. The centre was located next door to the oncology clinic and the managers were Macmillan professionals employed by the trust who worked closely with staff.

In the rheumatology clinic, staff promoted patient information leaflets and workshops on managing symptoms and changes in lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There was a trust-wide consent policy, which staff could access through the trust intranet. We saw that this policy included obtaining consent for treating all patients including adults with reduced capacity to make independent decisions, patients with communication difficulties and children and young people.

Staff made sure patients consented to treatment based on all the information available. We were told by staff that appropriate consent was obtained from the patient prior to any examination or treatment. In clinics where children were treated outside of paediatric department, staff described how they would discuss the appointment with the child and explain the equipment in the room so the child was not scared or uncomfortable. Staff were able to contact the paediatric clinic if they needed advice.

Mental Capacity Act and Deprivation of Liberty training completion

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a trust-wide mental health liaison team and staff told us they knew how to contact them if they needed advice or had concerns about a patient. Staff were trained in the Mental Capacity Act level one and two as part of their mandatory training.

Trust level

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from 1 April 2019 to 21 July 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>189</td>
<td>189</td>
<td>100.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>175</td>
<td>187</td>
<td>93.6%</td>
<td>85%</td>
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</table>

In outpatients the target was met for two of the two MCA/DOLS training modules for which qualified nursing staff were eligible.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>1 April 2019 to 21 July 2019</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>85%</td>
</tr>
</tbody>
</table>

In outpatients the target was met for one of the two MCA/DOLS training modules for which
medical staff were eligible. This was a small percentage that was only for one member of staff and therefore not a significant concern.

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff taking time to interact with patients and those close to them in a respectful and considerate way. Staff greeted patients and introduced themselves. Staff cared about their patients and patients were pleased to see faces they recognised. We heard one patient say to a staff member, ‘I hope I see you again’ as they left the treatment room. We saw patient thank you cards which thanked staff for their care and compassion. Patients told us they were aware they could talk to volunteers in the department if they needed help.

Staff were discreet and responsive when caring for patients. Patients told us that the clinic information screen showed numbers which meant their names were not displayed for others to see. They told us that staff were available to help if there was no screen in the clinic.

Patients said staff treated them well and with kindness. We read cards given to staff in clinics thanking them for their care and support. Patients told us that reception staff were welcoming and friendly. One patient wrote about ‘amazing admin staff in ENT (ear, nose and throat) outpatients.’ While another wrote that they were ‘very grateful to the whole Rheumatology team.’

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. One relative wrote to thank staff ‘…for everything you did for my wife during her treatment. You are kind, considerate, helpful, friendly and truly professional.’

Staff undertook training on breaking bad news and showed empathy when having difficult conversations. Staff told us that they were able to refer patients from the oncology clinic to the Macmillan support team which included a counselling service. They also told us that they had a quiet room where they could talk to patients and families in private. In the surgical and ENT outpatient departments we were shown similar rooms available for quiet discussions away from clinic waiting areas. We did not see staff needing to talk to patients in this way but saw staff being kind and patient with patients who were discussing concerns about appointments.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We saw a message from a patient who wrote ‘Thank you to receptionist in Ear Department for sorting my hearing aid so efficiently.’
Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients’ told us that if there was a delay to a clinic they were informed by the staff or by messages on the clinic information screen. A patient wrote that ‘dietitians helping me with my diabetes were amazing’. A patient told us that the consultant in the respiratory clinic ‘was absolutely fantastic’. They said that they were always sent a letter after the appointment, as was their GP. They reported they felt informed.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw posters in clinics advertising the friends and family test. We also saw red post boxes with comment slips available for more direct responses. In the audiology clinic, we saw a poster that invited patients to help shape the department and become involved in service improvement projects.

Patients gave positive feedback about the service. We spoke to seven patients who were positive about their experience. One patient commented to us that the consultant was running late but they knew they would not be rushed when they were seen. We saw a ‘Wonder wall’ in the corridor where patients and visitors could leave messages and compliments about outpatient services. For example, one patient wrote ‘Absolutely brilliant service at ENT. An overstretched service but always first class care.’

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Departments were involved in planning and organising services to meet the needs of the local population. We were told that one department had provided support to a charity by providing a drop-in service for advice on osteoporosis and arthritis in a community centre based within a local shopping centre. Staff told us that they were waiting for feedback from the charity before running more sessions. We were shown departments that offered workshops for patients run by other staff groups. These included rheumatology programmes on managing symptom flare ups, self-management of fatigue, pain management and ‘Best foot forward’ with a podiatry foot care specialist. Staff told us that patients could access support for managing medicines.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests each visit. We were told of plans in one department to run one stop clinics to see, treat and discharge. The plan was to refer patients to support groups for ongoing support. Staff in cardiology told us of a one stop service where patients were seen for one longer appointment with positive feedback from patients. However, a patient told us that they had several appointments in different clinics and would have appreciated being able to have them all on the same day.

Blood testing in outpatients department was in the phlebotomy clinic. Patients took a ticket number on arrival and waited to be called for their blood test through an automated announcement system.
However, due to the layout of the clinic cubicles, it was not always clear to patients where they should go once called. Staff in the clinic had developed a meet and greet service in response to this. We saw that at busy times one staff member would stand in the waiting area and as each patient was seen preparing to leave the next patient would be guided to the available cubicle. The same staff member would also answer the phone, collect blood samples in sealed pods and place them in the delivery chute where it was transported to the lab. Staff told us this had significantly improved the patient experience as patients were reporting less confusion in the waiting area and faster flow through the clinic.

Services relieved pressure on other departments. Staff told us that if a child needed to be treated in an adult clinic, where they would not normally expect to be seen, staff would assess the risk at the time based on the needs of the patients. Staff told us that some clinics would provide cover for staff in other clinics where possible. This meant that clinics could continue to run in the event of unexpected staff absence or increased capacity. Staff told us that this would often happen in clinics that were similar specialities or managed by the same matron.

Managers monitored and took action to minimise missed appointments. The booking centre staff encouraged all patients to attend appointments especially if they were booked under two week national standards. Staff offered patients alternative appointments if this was clinically appropriate.

Managers ensured that patients who did not attend appointments were contacted. The booking centre staff told us that they would contact the clinician team for the patient if they did not attend an appointment twice. This was in line with the trust policy. Consultants were made aware of children that were not brought to booked appointments and they would contact the parents.

**Did not attend rate**

From 01 March 2018 to 28 February 2019, the ‘did not attend’ rate was lower at both the trust and at Queen Alexandra Hospital compared to the England Average.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Portsmouth Hospitals NHS Trust and Queen Alexandra Hospital**

(Source: Hospital Episode Statistics)
Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patients with specific requirements were not routinely flagged on the trust patient information system. Staff showed us that the trust wide electronic system allowed for staff to document transport needs, wheelchair use, requirement for a translator and the language required. The booking centre was able to print letters in large print and on easier to read coloured paper for new appointments. Appointments could also be sent to applications on smart mobile phones that read letters aloud. Staff told us that individual clinics recorded additional requirements for accessible information such as large print letters for each follow up appointment or on their own databases. This meant that a patient had to request accessible information at every follow up appointment or at each clinic.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us that they could send large print letters to patients on request. However, there was no common approach for all clinics. Some staff told us that they had not been asked to provide alternative print letters and were not sure of the process to do so. Staff told us that in some clinics patients would be asked how they wished to be contacted. However, this was not evident in all clinics. Staff told us that in some clinics hearing loops systems to support those with hearing loss were not available.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff told us that they would contact translators including those who used sign language if they were unable to communicate verbally with a patient. However, we were not able to see this during this inspection.

The service had information leaflets available in languages spoken by the patients and the local community. We saw leaflets which informed patients they could request a translator and information written in another language or in large print. However, we did not see any leaflets that were pre-printed and immediately available in other formats.

Managers made sure staff, and patients, loved ones and carers could get help from translators or signers when needed. Staff told us they could contact translators offering both face to face and telephone translation for patients who did not speak English. Staff told us that they always aimed to book a face-to-face translator once the appointment was booked but could call a telephone translator if it was required urgently. However, we talked to one patient whose first language was not English and was unable to converse with us. Their appointment had been booked by their GP and no translator had been arranged. We spoke to the reception staff who told us they would inform the consultant and the appointment would be rearranged if necessary. Later we returned and were told the patient had been seen and the appointment did not have to be rebooked.

Staff told us that they worked closely with the services that provided patient transport to clinics to help patients access transport to and from their appointment. They would contact transport services if there was a delay in collection or appointments.

Access and flow
People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to treat and discharge patients were in line with national standards for most speciality clinics. However, patients were still waiting extended periods for follow-up appointments in some clinics.

Managers monitored waiting times and made plans for patients to access services when needed and receive treatment within agreed timeframes and national targets. Senior staff told us that the waiting list for each speciality was discussed weekly. Staff attended a weekly meeting and information from this was taken to a trust waiting list meeting, also held weekly. Staff told us that the number of patients on the list were discussed and plans to manage the numbers made. At the following meeting, the outcome of those actions were checked. We were unable to attend this meeting on this inspection. We were told by staff at the booking centre that they would monitor the waiting list for each speciality to make sure it was up to date and accurate. This meant the outpatient waiting list stated the number of patients waiting for each consultant and department. However, in the audiology department there was a 12 month waiting list for hearing aids. Following discussion with commissioners and senior management there was a new target in place to reduce the waiting time to 35 weeks by the end of March 2020. This was yet to be audited.

Managers worked to keep the number of cancelled appointments to a minimum. At the last inspection, we found a standard operating procedure for cancelled appointments had been developed. We spoke with administrative and clinical staff who were aware of this process and how to make sure that there was a clinical agreement from a consultant when an appointment was cancelled or rescheduled. Staff told us they believed there had been an immediate improvement in the process as a result. Administration staff told us that if a clinic was cancelled they would discuss all the patients with a consultant within three or four days and either find an appointment with another doctor or book another date for the patient to be seen. This was in line with the standard operating procedure for cancelled appointments. The booking centre was responsible for contacting patients but only once there was another clinic for the patients to be booked into. However, one patient reported that they had repeatedly had appointments cancelled with no explanation.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. Appointments were cancelled by letter or telephone. We spoke to one patient who had arrived for an appointment to be told it had been cancelled. Staff told them that a letter to cancel the appointment had been posted but the patient said they had not received it. The patient had also received a text to confirm the appointment. Staff asked them to wait while they tried to arrange for them to be seen by another doctor.

An external call centre managed booking for all new outpatient appointments. Follow up bookings were made in clinic or patients were sent an appointment by letter. Staff at the centre were trained to work in all specialities so that they were able to cover each other.

Patients told us that the booking system was straightforward. They reported booking appointments was an easy process and some had used the online booking system. Most had received reminders of the appointment by text message. Other patients told us that they would arrange their next appointment as they left the clinic while others had follow up appointments sent to them. One patient reported that they had to reschedule appointments as they had received two for the same time and day. Patients told us that they found reception staff easy to approach if they needed to change appointments. Patients were also able to cancel and re-book appointments online or through the choose and book system.
Staff understood the booking process for new and follow-up appointments. All the staff that we spoke to told us that new patient appointments were made through the outpatient booking centre or directly by GPs. Patients who required an appointment within the national guidance of two weeks could be booked by the GP. Each clinic had different methods for booking follow up appointments. There was no consistent approach across the departments. In urology, patients were offered an immediate booking and a letter sent to confirm it.

Patients told us that they found the check-in process straightforward and staff helpful. The check in kiosks printed information on where to find clinics. However, some patients told us that finding the clinic on the first appointment was confusing at times. Staff told us that the screen displayed a three-figure code for each patient that was then shown in the waiting room. Patients were able to see when they were going to be seen without staff calling their name. This meant that patient confidentiality could be maintained. However, we noted that not all clinics used the system. Staff told us that some clinics had multiple waiting rooms and it was not possible to have screens in every area. Staff also told us that patients could check-in in other parts of the hospital and may not have arrived in the correct clinic when called.

We saw clinics where patients took ticket numbers instead of booking in for appointments beforehand. This meant that patients were seen in order of arrival. We saw that flow through some departments was more streamlined where patients were able to move from one area to another as they saw clinicians. In others, patients were seen in corridors before being taken to the next waiting area.

Delays to clinics were clearly displayed on screens in those clinics that used them. Staff told us that they were able to offer lunch or support with parking if the clinic was running more than two hours late. However, several patients reported that they were not always made aware of delays to clinics.

Staff made sure patients were able to locate rooms within clinic areas. In surgical and ear, nose and throat outpatients staff showed us coloured cards on treatment room doors. Staff told us that this meant patients could see the colour allocated to a doctor and find the room with ease. In surgical outpatients, the coloured card also had the colour in text to assist patients who were colour blind. Staff told us that the whole team were proud of this system and one consultant had offered to wear a matching tie.

Some clinics, for example Rheumatology, ensured they used all available appointments by using a daily report on empty slots. Staff told us they would triage patients from the help line and use these appointments to see patients in urgent need. Staff told us that this would be audited to establish if it was an efficient use of the appointments.

Referrals between clinics were managed differently. We spoke to staff who referred patients to other services using paper referrals. Other services contacted the teams by telephone. Doctors in the emergency eye clinic carried a pager so that they could be contacted by GPs or teams within the hospital.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From August 2018 to July 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways has been similar to the England overall performance. The latest figures for July 2019, showed 85.0% of patients awaiting treatment had been waiting less than 18 weeks versus the England average of 86.1%.
Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Portsmouth Hospitals NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Ten specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>99.9%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>97.8%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>97.2%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>93.9%</td>
<td>79.6%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>92.2%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>91.8%</td>
<td>85.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>89.6%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>89.2%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>85.1%</td>
<td>83.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>84.8%</td>
<td>83.8%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>85.9%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Other</td>
<td>84.9%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>83.7%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>75.2%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>53.8%</td>
<td>80.5%</td>
</tr>
</tbody>
</table>
(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From August 2018 to July 2019 the trust’s referral to treatment time (RTT) for incomplete pathways has been worse the England overall performance. The latest figures for July 2019, showed 82.6% of this group of patients were treated within 18 weeks versus the England average of 85.3%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Portsmouth Hospitals NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Nine specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>99.5%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>99.0%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>98.5%</td>
<td>89.3%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>94.8%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>93.8%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>92.2%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>89.7%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>89.4%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>86.1%</td>
<td>83.4%</td>
</tr>
</tbody>
</table>
Seven specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>84.9%</td>
<td>88.6%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>82.2%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>80.9%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>80.0%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>72.6%</td>
<td>82.2%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>72.0%</td>
<td>81.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>63.4%</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

*Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Portsmouth Hospitals NHS Trust*

(Source: NHS England – Cancer Waits)

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Portsmouth Hospitals NHS Trust

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Portsmouth Hospitals NHS Trust

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. We saw posters and leaflets in the clinics we visited explaining the process for patients and visitors to raise concerns and make complaints.
Staff understood the policy on complaints and knew how to handle them. Staff told us that if a patient made a complaint to them in person they would direct them to the patient advice and liaison service (PALS). Senior administration staff also told us that they had attended a workshop on how to manage complaints, this was not available to all staff but the information was shared with the team. One administration manager told us that they would contact the patient to acknowledge the complaint had been received and contact PALS for their advice and support.

Complaints in the audiology clinic had decreased. Staff told us that when the waiting list for follow up appointments started to increase the service was unable to warn patients of the length of time they may be waiting for an appointment. Staff told us that they now had a clear understanding of the delay and would inform patients immediately of the waiting time. The department had given PALS a standardised response to patients that explained the delay. Staff told us that this had reduced the number of complaints being made in the department as patients were better informed.

Managers investigated complaints and identified themes. We reviewed five complaints and responses from the trust. Each complainant had received a response within the time frame set out in the trust complaints policy. We saw department and divisional governance meeting minutes where complaints were discussed and actions to be taken were documented. At the divisional meeting themes were identified, for example waiting list and delays in test results being shared with GPs. Staff told us the themes were shared informally and that they were made aware if there was a team meeting in the department. One manager told us they were informed of every complaint, would investigate it and share the outcome with the staff involved.

Staff knew how to acknowledge complaints and patients received feedback from managers after investigation into their complaint. Staff told us that the complaints they received face to face were often about waiting times in clinics. One nurse told us they worked in a clinic that runs separate clinics for different specialities and patients would complain that others were being seen quicker. Staff now explained to patients that there are different waiting times for different doctors and this was made clear on arrival.

Staff could give examples of how they used patient feedback to improve daily practice. Staff in the blood testing clinic told us they had used patient feedback to develop a meet and greet process to improve patient flow through the clinic and reduce waiting times.

**Summary of complaints**

**Trust level**

From June 2018 to May 2019 the trust received 246 complaints in relation to outpatients at the trust (33.7% of total complaints received by the trust). The trust took an average of 39.6 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be closed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>90</td>
<td>36.6%</td>
</tr>
<tr>
<td>Date for appointment-delay/cancellation (outpatient)</td>
<td>47</td>
<td>19.1%</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>24</td>
<td>9.8%</td>
</tr>
<tr>
<td>Communication (oral)</td>
<td>23</td>
<td>9.3%</td>
</tr>
<tr>
<td>Type of complaint</td>
<td>Number of complaints</td>
<td>Percentage of total</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Communication (written)</td>
<td>17</td>
<td>6.9%</td>
</tr>
<tr>
<td>Access to Treatment</td>
<td>13</td>
<td>5.3%</td>
</tr>
<tr>
<td>Date of admission / attendance (Inpatient)</td>
<td>8</td>
<td>3.3%</td>
</tr>
<tr>
<td>Patient privacy / dignity</td>
<td>5</td>
<td>2.0%</td>
</tr>
<tr>
<td>Outpatient and other clinics</td>
<td>4</td>
<td>1.6%</td>
</tr>
<tr>
<td>Test results</td>
<td>4</td>
<td>1.6%</td>
</tr>
<tr>
<td>Admissions / transfers / discharge procedure</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Personal records</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Patient status</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>Aids / appliances / equipment</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>246</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From June 2018 to May 2019 there were no compliments about outpatients at the trust.

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

Is the service well-led?

**Leadership**

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust had developed a new divisional structure with outpatients in the surgery and outpatients division. At the last inspection, we found there was no overarching governance structure for outpatient services. Outpatient services had been managed under clinical service centres specific to the clinical specialities. Since then the trust had developed a divisional structure with a senior management team that was responsible for the services in the surgery and outpatients division.

Leaders were approachable and visible to staff. Staff told us that they were able to talk to the senior leadership team and reported that the trust executive team were often seen around the departments including offices that were on different sites. Staff told us that there were occasions when an informal chat about a service developed into a more formal discussion leading to new ways of working. However, due to the recent changes in the divisional team, some staff told us they were still unsure of who the divisional leadership were.

Many senior staff told us that they were new in post and the teams were still getting used to new structures. The divisional leadership team had been working together for several months as a new team. They told us that they believed it was a more comprehensive structure than the previous care group system.

The leadership team had access to training and development. The team told us that they were able to attend a leadership management course which allowed them to develop networks and skills. They reported that there was ongoing coaching available afterwards.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The divisional leadership team told us about the strategy for the division which was launched in July 2019. On our last inspection, the trust did not have a strategy for outpatient services. The team told us that there was a vision for surgery but we were not clear on the vision for outpatients. Following our inspection, we requested the divisional vision and strategy document this showed us that the divisional leadership team shared the outpatient strategy with managers for it to be discussed with the staff in their clinics and departments. The document also showed that the leadership team invited staff to ask questions about the new divisional structure and vision.

Senior clinic staff told us that they attended local strategy meetings. Staff told us that some departments had a strategy and were aware of a trust strategy. However, they were not clear on the overarching divisional strategy for outpatients.

The team confirmed that the trust had a project team developing the paperless system for the outpatient department. The team understood that clinicians were concerned but audits of clinics that were paperless had been positive. They told us that some departments, for example, the eye clinic were not part of the current project because they used different computer programmes and systems.

The team told us that they were determined to maintain financial stability for the division, have the correct skill mix of staff in the departments with happy and enthusiastic staff. The team wanted to build strategic links with other organisations.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The divisional leadership team told us that the culture within the trust had improved. On our last inspection, we found there was a poor culture where staff concerns were not always taken seriously and there was low staff morale in some outpatient areas. The team told us that the executive leadership team were approachable and had a clear vision of governance within the trust. The team told us that they were proud of the staff in the division and the development of quality services. They were encouraged to see staff talking together with visions of how they wanted services to develop, making and sharing suggestions freely.

Senior staff were supportive of staff and staff told us they felt valued. On this inspection, we found that staff reported an improved culture where teams worked well together in each department. One manager told us that they were ‘only as good as your weakest link, so you need to invest’ in the staff. However, staff told us that at times they felt that the impact of staff shortages on team morale was not always recognised by consultants and managers.
Staff told us that being part of a team that had received national accreditation was good for morale. This was reported to help staff feel more valued when departments were busy or short staffed. We were told that in the plaster room in fracture clinic staff were going to celebrate National Casting Day in November 2019. This gave staff the opportunity to share information about their service with the public and staff and celebrate the skill of the staff.

Staff told us that they were proud to work in the trust. We spoke to staff who told us ‘I love my job’. Another staff member told us they would not want to work anywhere else. Staff also told us they would be happy to have their own family treated at the trust.

The division had recently launched a social media account to celebrate success. Staff told us that they were aware of the hashtag #proudtobePHT scheme where staff could use the phase to link comments on social media to the trust. Staff told us about a trust awards programme where teams and individuals could be nominated for good practice and recognised for it at trust level. We saw the wonder wall where staff and public could leave notes to share positive feedback or praise. One staff member told us that the trust board contributed to flowers for a member of staff who was unwell which the team appreciated greatly.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Most staff at each level were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The divisional leadership team included representatives from the finance and human resources departments. They reported that this meant a more thorough process for divisional governance. There were a series of monthly meetings that monitored performance and developments within the division. These included the weekly patient safety meeting also attended by a patient representative. The team described an ambition to have a patient representative at the divisional governance meeting. The managers told us that they passed information from governance meetings to staff in the department through team meetings. However, they understood that some messages did not get through and they were looking to improve the line of communication.

The team told us that they had a clear vision for meeting financial targets. The new structure meant that the team were able to identify a divisional finance strategy and maintain control of their own budget.

We found that not all staff were aware of their responsibilities regarding governance, however they were updated on performance through the various team meeting structures. We spoke to senior nurses who told us that they were able to attend governance meetings for their specialities and discuss risks and developments. Sisters told us they attended a senior sister meeting every three months where they were able to have peer support and share concerns.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior staff told us that they had risk registers for their services. On the last inspection, we saw that although the trust had systems for identifying and managing risks, not all risks identified by
staff were on the risk register. On this inspection, senior staff told us that they had risk registers for their services. They were able to identify top risks as capacity for appointments, information technology and the need to redevelop older buildings.

The risks from the local registers were added to the divisional risk register. The divisional risks reflected national issues relating to consultants not being able to take on additional hours, training for clinicians to review and investigate serious incidents. Outpatient department risks included estates especially the eye department structure and age.

Managers and staff carried out a programme of repeated audits to check improvement over time. However, there seemed to be no overarching strategy for audit which led to an inconsistent approach to audits in the outpatient departments. Each department audited different things, using different paperwork.

**Information management**

The service collected reliable data and analysed it to understand performance, make decisions and improvements. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff told us that there was the opportunity to share department performance and initiatives at governance meetings. One senior staff member told us that they had used one meeting to influence other clinics in the use of the paperless record system.

Staff told us they raised concerns about the waiting lists. We were told that patients were waiting for follow up appointments in the audiology clinic for 12 months due to staff vacancies and increased demand on the service. Staff told us that to reduce the risk to patient care, patients were reviewed for priority and given appointments according to set criteria, for example moderate hearing loss or a combined visual and hearing impairment. We were told that locum staff were now employed to assist in reducing the waiting list but during summer months it was harder to employ locum staff. Staff told us that this was being discussed with senior management and commissioners and was on the department risk register.

The service collected reliable data and analysed it. Senior staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. We were shown data bases used in different departments to gather information on performance and used for audit. The information systems were electronic and secure. Staff told us that these audits were shared with the trust management and submitted to external organisations as required. For example, compliance with the National Institute for Health and Care Excellence (NICE) standards in rheumatology.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The leadership team had discussed methods for helping staff to understand the new structure. They told us that they were in the process of spending time with staff to increase their visibility. The team told us that they were running staff and patient forums set up by the trust and would be reviewing these to see if there were alternative methods that would be useful. The team were
running drop-in sessions for staff to meet the team and were planning to have a divisional newsletter or workforce forum for staff information.

Managers told us that they ran ‘Listening in to action’ events where staff were invited to ask any questions. These events were run at different times of the day to allow as many staff as possible to attend and this had received positive feedback. However, these were held after the strategy was published and did not feed into its development. It was not clear that staff had been consulted before the strategy had been written. The team told us that it would be included in future.

Staff were able to feedback using staff surveys. We were told that staff completed a trust staff survey every three months and a national staff survey each year. The results were fed back to the staff and actions that needed to be taken as a result were shared. After the inspection we saw results from the trust staff survey for April to June 2019. Of the staff who responded 59% would recommend the trust as a place to work and 82% as a place to receive treatment. However, while these were below the trust targets of 73% and 88% for each question they were an improvement on the same time in 2018.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff told us that they were able to make suggestions for improving services and were supported by managers to act on them. In orthopaedics and fracture clinic, we saw boards that displayed the trust values of always improving, working as one team, showing compassion and working for patients. Under each heading staff wrote how they had achieved that for the week. Staff told us that on a Monday they would discuss these as a team and update them on Friday. We saw statements including having a suggestion box for staff and patients, respecting each other, sending flowers to a sick colleague and offering refreshments to patients who wait in clinic.

We were told that the blood testing clinic ‘Meet and Greet’ scheme was as a result of office staff hearing patients complain in the waiting area. The manager told us that as a result the service had received positive feedback in person and through the friends and family test.

Staff in the eye clinic told us that there was a new role of Glaucoma Failsafe Officer. This post developed from a patient safety meeting following incidents involving delayed treatment for glaucoma patients. The Band 3 post provided support to the glaucoma service and the administration team and ensured glaucoma patients received follow up appointments at the recommended time. The failsafe officer also monitored the outpatients waiting list for glaucoma patients in discussion with the consultant and escalated urgent patients on the outpatient waiting list. At the time of this inspection it was too soon to assess the impact of this new post on the service.

Staff told us that while there were opportunities for development of services, some clinics did not have the staff or space to make them a reality. Staff reported that they were restricted by the design and age of some departments.