University Hospital Southampton NHS Foundation Trust

Evidence appendix

Southampton General Hospital
Tremona Road,
Southampton,
Hampshire,
SO16 6YD

Date of inspection visit:
4 December to 24 January 2019

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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

University Hospital Southampton NHS Foundation Trust has had foundation trust status since 1 October 2011. It is one of the country’s largest university hospitals, and provides local inpatient services to a population of 1.9 million people living in Southampton and south Hampshire. It also provides specialist services to over 3.7 million people living in southern England and the Channel Islands. Services include urgent and emergency care, medicine, surgery, critical care, maternity and gynaecology, services for children and young people, end of life care, and outpatient services including diagnostic imaging. There are approximately 11,500 staff employed to deliver services.

The trust is also a major centre for teaching and research in association with the University of Southampton and partners including the Medical Research Council and Wellcome Trust.
### Acute hospital sites at the trust

A list of the acute hospitals at University Hospital Southampton NHS Foundation Trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southampton General Hospital <strong>(SGH)</strong></td>
<td>Tremona Rd, Southampton SO16 6YD</td>
<td>Neurosciences, oncology, pathology, cardiology, critical care, acute medicine unit and emergency department, eye casualty, outpatient clinics, diagnostic and treatment work, surgery, research, education and training.</td>
<td>Southampton</td>
</tr>
<tr>
<td>Countess Mountbatten House <strong>(CMH)</strong></td>
<td>Botley Road, West End, Southampton, SO30 3JB</td>
<td>Palliative care</td>
<td>Greater Southampton</td>
</tr>
<tr>
<td>Royal South Hants <strong>(RSH)</strong></td>
<td>Brintons Terrace, Southampton SO14 0YG</td>
<td>Dietetics, speech and language therapy, audiology syncope clinic, dermatology, radiology, and neurology outpatients</td>
<td>Hampshire and the Isle of Wight, including Southampton</td>
</tr>
<tr>
<td>Princess Anne Hospital <strong>(PAH)</strong></td>
<td>Coxford Rd, Southampton SO16 5YA</td>
<td>Maternity care, foetal and maternal medicine, genetics and breast screening.</td>
<td>Southampton</td>
</tr>
<tr>
<td>St Marys Hospital</td>
<td>1 Johnson St, Southampton SO14 1LT</td>
<td>Medical Oncology and Clinical Oncology</td>
<td>Southampton</td>
</tr>
<tr>
<td>Lymington New Forest Hospital <strong>(LNFH)</strong></td>
<td>Wellworthy Rd, Lymington SO41 8QD</td>
<td>Diagnostics and outpatient services</td>
<td>Southampton</td>
</tr>
</tbody>
</table>

(Source: [http://www.uhs.nhs.uk/Home.aspx](http://www.uhs.nhs.uk/Home.aspx))
Is this organisation well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Leaders had the experience, capacity, capability and integrity to ensure the strategy could be delivered and risks to performance addressed.

As part of the inspection we interviewed members of the board, both the executive and non-executive directors, and some senior staff across the trust. We looked at a range of performance and quality reports, audits and action plans. We reviewed previous board meeting minutes, risk registers, board assurance framework and papers to the board. We looked at investigations of deaths, serious incidents, complaints and sought feedback from staff and key stakeholders, such as the clinical commission groups (CCGs), and Healthwatch.

Since the last inspection in 2017 the trust had further developed a strong senior leadership team with the appointment of a new and experienced chief executive in September 2018. The chair has continued in post and was appointed in April 2016 and is supported by some long-standing board members as well as several new non-executive director (NED) appointments as well as an associate director of corporate affairs in 2018.

There was an embedded system of leadership development and succession planning for all senior roles. For example, the chief financial officer joined the trust in February 2016 and was the interim chief executive in April to September 2018; and at the time of inspection was due to be confirmed as the deputy chief executive.

Services were managed in five divisions and within each division there were care groups. The divisional management team consisted of a divisional clinical director, divisional director of operations and divisional head of nursing or professions. They were supported by a divisional research and development lead, divisional finance manager, divisional planning and business development or strategy manager, divisional education lead, divisional human resources business partner and a divisional governance manager. The clinical divisions reported overall to the chief operating officer.

The chief pharmacist (CP) was an experienced leader with the skills, abilities and commitment to provide high-quality pharmacy services to people. The CP was visible and accessible to all staff. Staff were provided with appropriate development opportunities which contributed to effective succession planning of the pharmacy team.

The NEDs sat or chaired on committees that included the audit and risk, quality, strategy and finance. The audit and risk committee role included an oversight function in relation to financial reporting, systems of internal control, risk management, effective use of resources, appointment and effectiveness of external and internal auditors. There was a quarterly review of the board assurance framework and operational risk register, together with actions to mitigate or manage those risks.

The NEDs and executive leaders informed us of the financial challenge experienced in 2018 attributed to patient flow, delayed transfers of care and a lower elective rate such as in cardiology.
Actions were taken regarding recruitment and processes. There was a reprioritisation of capital expenditure and the trust had seen a turnaround in financial performance.

There was a Council of Governors (CoG); the collective body of 23 governors through which executive and non-executive directors explained their actions. The CoG worked closely with the trust board to make sure services were meeting the needs of the local community and gathered the views of the hospital's members. The CoG had the opportunity to comment on the development of strategic plans for the hospital and acted in a trustee role to ensure the hospital met its obligations. In addition, some of the statutory responsibilities of the CoG included: appointing the chair and non-executive directors, agreeing the appointment of the chief executive and appointing the trust's auditors.

The board members met every month. The trust published a monthly board report on its website which provided both the board and the public with an overview of performance such as for transformation and improvement, referral to treatment, cancer waiting times, staffing, education and training, research and development and estates. This report also included summary versions of quarterly reports submitted to the trust executive committee (TEC) which were in greater detail about patient experience, patient safety, clinical effectiveness and outcomes, and infection prevention. In addition, a separate finance board report was submitted monthly. The board held monthly study sessions during 2017/18 where strategic issues, along with emerging issues, were discussed.

We reviewed the personnel files for the non-executive directors and those of the executive team. Appropriate checks had been carried out in accordance with ‘Fit and Proper Person’ requirements. The trust had recently reviewed the files and had sought updated information as needed. The executive team had an appropriate range of skills, knowledge and experience.

**Board Members**

Of the executive board members at the trust, 0.0% were Black Minority Ethnic (BME) and 66.0% were female.

Of the non-executive board members 28.6% were BME and 42.8% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME  %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>66.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>28.6%</td>
<td>42.8%</td>
</tr>
<tr>
<td>All board members</td>
<td>28.6%</td>
<td>53.8%</td>
</tr>
</tbody>
</table>

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

**Vision and strategy**

**The trust had a vision for what it wanted to achieve**

There was a clear statement of vision and values known to staff and available on the trust website. “Our vision is to work with our partners at the leading edge of healthcare for the benefit of our patients” and a mission statement: “Our mission is to be better every day”.
The values were:

- Putting patients first
- Working together
- Always improving

The new chief executive was reviewing the vision and mission of the trust alongside the trust’s strategic plans. There were various strategies such as for workforce and education that underpinned the trusts overall strategy. The trust had a medicines optimisation strategy in place, which also incorporated the trust strategy and shared widely throughout the trust via multidisciplinary meetings. We were told, and saw evidence from meeting minutes, that the hospital management teams were involved and aware of the developments and achievements services.

The current challenges had been identified in the public document, “Forward Vision”, as capacity, finance and staffing.

The Moving Forward top eight priorities were headed as:

- Promote and live our values
- Improve safety, quality and productivity
- Our staff and our education mission
- Become a hospital without walls
- Specialised services
- Preventative care
- Discovery
- All stages of life

**Culture**

**Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

The trust’s strategy, vision and values underpinned a culture which was patient centred. The culture was positive, open and honest; staff were listened to and heard. There were systems for performance management of staff through the annual appraisals, which were aligned to the values. There were processes and procedures for managers to follow if staff did not meet performance expectations. We were told of examples where the procedures had been applied where staff had not met the trust values.

The trust had appointed a Guardian of Safe Working Hours (GSWH) to provide assurance to the trust board, the General Medical Council and Health Education England and to the doctors themselves that doctors in training were safely rostered and working hours were reported as compliant with their terms and conditions of service. The guardian was required to raise concerns to the trust board and potentially to external bodies if this was not the case. There were no performance issues raised. Junior doctor’s meetings were regularly held and had identified the need to improve IT support for which a survey was underway to ensure the correct support would be given.
The director of nursing and organisational development recognised reflecting a national picture there were further opportunities for the culture to develop across the trust in respect of allied health professionals (AHPs) to have a stronger voice with design and decision for patient care. The trust was looking to appoint an associate director for AHPs, the job description was in development at the time of inspection. The trust was aware of the need to develop the equality and diversity further in the trusts day to day work and for supporting opportunities for career progression. There was a Black, Asian and Minority Ethnic (BAME) network with a relatively small membership. We met with the network representatives and invited all staff to a BAME focus group, held in November 2018. Staff said they had not felt they were treated equitably by the trust. They said they felt there were obstacles to their development and engagement with the trust. We were told the trust had employed a consultant to review the development of an improved culture in support of equality of staff from a BAME background and work with the trust and the network to support collaborative working and improve the networks membership. The focus group did not feel this had yet made any significant difference. Staff felt they were required to seek permission to attend support groups and that cultural difference was not celebrated. Other staff spoken with during our core service inspection did not necessarily have the same views and many BAME staff spoken with were happy working at the trust.

There was a newly appointed equality and diversity lead who came into post two weeks before the inspection. They informed us the trust had plans underway for a new strategy to meet the equality and diversity needs of the staff as well as patient groups. The trust had an established disability group and had supported staff requiring reasonable adjustments. There was a faith and belief group providing a virtual network through social media run by the chaplaincy, for every denomination.

To improve the culture the trust had a freedom to speak up guardian (FTSUG). There was awareness of this through to the board level. The FTSUG lead was appointed in October 2017, 2.5 days per week on this role and had attended the national training and become a national trainer- ‘train the trainer’ for the region. There were arrangements in place for establishing FTSU champions as advertised in December 2018 with 13 recently recruited including in pharmacy, radiology and junior doctors. Training for champions had been arranged for February 2019 and would be done jointly with two other local trusts. There was a support network across Hampshire, quarterly meetings and adhoc contact with other trust based FTSUGs.

The FTSUG lead had developed a process for who was responsible for specific issues and was clear the role was to ensure issues were addressed. There had been 40 cases over the last year and we were told 80% had been resolved to the satisfaction of person raising concerns. The key concern was bullying and harassment. The October 2018 board report included trends and challenges, patient safety issues and cases in progress. There had been three patient safety concerns escalated to the chief executive who appointed an external investigator to look at the concerns. An example of change was the revision of the recruitment policy following concerns being raised to ensure processes were more inclusive for BAME staff. The FTSUG worked closely with the equality and diversity lead as some of the issues raised by staff were related to equality and diversity.

**Staff Diversity**

It was noted the trust did not have a diverse workforce at senior leadership level. The trust told us it planned to build on the diversity at board level in gender and ethnicity and in senior roles.
The trust action plan to August 2018 informed us that there had been a growth in the number of BAME staff at Band 7 to 15% by 2023. There had been an increase from 6.72% in 2017 to 7.2% in 2018 as recorded in the Workforce Race Equality Standards.

The current information the trust provided showed the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff</th>
<th>Nursing and midwifery staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Nursing &amp; Health visiting staff</td>
</tr>
<tr>
<td>White</td>
<td>69%</td>
<td>80%</td>
</tr>
<tr>
<td>BME British</td>
<td>19%</td>
<td>13%</td>
</tr>
<tr>
<td>BME non- British</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>5%</td>
<td>1%</td>
</tr>
</tbody>
</table>

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

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

The staff survey results for 2017/2018 showed trust staff engagement had remained consistently high (3.95) compared to the NHS average (3.79). The trust was ranked number seven in acute trusts, and the third best university teaching hospital. The trust ranked as the best in the south for recommendation as a place to work and be treated. It was also ranked second in good communication between senior managers and staff.

The trust said to mitigate risks related to staffing they had employed a range of strategies to focus on making the trust an attractive employer. For example, they had developed Band 4 posts and apprentices, promoted the ‘Think UHS’ recruitment brand, continued to recruit within Europe and further afield and worked with universities to increase student nurses. To enhance retention had increased medical overseas fellow’s posts, reviewed all junior doctor rotas considering the new contract, used flexible and temporary staff when needed, created different roles linked to their research agenda and reviewed training and education.

The head of leadership development, said the trust provided leadership development opportunities for managers, on-line learning, were to create a virtual learning environment. The trust had a budget of £120,000 just for leadership programmes, spent each year on internal foundation leadership programmes in partnership with Solent University. We were told this had led to staff progressing in their careers following the programme.

The trust had embraced talent management in a variety of ways including training for care group clinical leads, and a two-day leadership course for consultants. At least 264 staff had completed or were undertaking a clinical leaders programme specially designed internally for Band 7 ward and department leaders of nursing, midwifery and allied health professionals. The University Hospital Southampton graduate development scheme commenced for four staff in September 2018 with aim of developing future operational managers with the skills and experience to take on senior leadership positions at the trust.
The trust has 26 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff recommendation of the trust as a place to work or receive treatment</td>
<td>4.05</td>
<td>3.75</td>
</tr>
<tr>
<td>2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.94</td>
<td>3.91</td>
</tr>
<tr>
<td>3. Percentage of staff agreeing that their role makes a difference to patients/ service users</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>4. Staff motivation at work</td>
<td>3.97</td>
<td>3.92</td>
</tr>
<tr>
<td>5. Recognition and value of staff by managers and the organisation</td>
<td>3.61</td>
<td>3.45</td>
</tr>
<tr>
<td>6. Percentage of staff reporting good communication between senior management and staff</td>
<td>44%</td>
<td>33%</td>
</tr>
<tr>
<td>7. Staff ability to contribute towards improvements at work</td>
<td>76%</td>
<td>70%</td>
</tr>
<tr>
<td>8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.99</td>
<td>3.91</td>
</tr>
<tr>
<td>9. Effective team working</td>
<td>3.82</td>
<td>3.72</td>
</tr>
<tr>
<td>10. Support from immediate managers</td>
<td>3.84</td>
<td>3.74</td>
</tr>
<tr>
<td>11. Percentage of staff appraised in last 12 months</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>12. Quality of appraisals</td>
<td>3.25</td>
<td>3.11</td>
</tr>
<tr>
<td>13. Quality of non-mandatory training, learning or development</td>
<td>4.12</td>
<td>4.05</td>
</tr>
<tr>
<td>14. Staff satisfaction with resourcing and support</td>
<td>3.4</td>
<td>3.31</td>
</tr>
<tr>
<td>15. Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>59%</td>
<td>51%</td>
</tr>
<tr>
<td>16. Percentage of staff working extra hours</td>
<td>70%</td>
<td>72%</td>
</tr>
<tr>
<td>17. Percentage of staff feeling unwell due to work related stress in the last 12 months</td>
<td>35%</td>
<td>36%</td>
</tr>
<tr>
<td>18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.82</td>
<td>3.62</td>
</tr>
<tr>
<td>21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>88%</td>
<td>85%</td>
</tr>
</tbody>
</table>
23. Percentage of staff experiencing physical violence from staff in last 12 months | 2% | 2%

25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | 24% | 28%

26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | 21% | 25%

28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month | 30% | 31%

30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.87 | 3.73

31. Staff confidence and security in reporting unsafe clinical practice | 3.83 | 3.65

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

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

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>44%</td>
<td>45%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

### Workforce race equality standard

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

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

To preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.
Of the four questions above, the following questions showed a statistically significant difference in score between White and BAME staff:

- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)
Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored above the England average for recommending the trust as a place to receive care from September 2017 to August 2018.

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from July 2017 to June 2018 were below the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

The trust informed they rank in the top 10 acute trusts in the country for overall satisfaction of postgraduate trainees.

In the 2018 General Medical Council Survey the trust performed the same as expected for all 13 indicators.

<table>
<thead>
<tr>
<th>Survey area</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td>○</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>○</td>
</tr>
<tr>
<td>Clinical Supervision out of hours</td>
<td>○</td>
</tr>
<tr>
<td>Handover</td>
<td>○</td>
</tr>
<tr>
<td>Induction</td>
<td>○</td>
</tr>
<tr>
<td>Adequate Experience</td>
<td>○</td>
</tr>
<tr>
<td>Supportive environment</td>
<td>○</td>
</tr>
<tr>
<td>Work Load</td>
<td>○</td>
</tr>
<tr>
<td>Educational Supervision</td>
<td>○</td>
</tr>
<tr>
<td>Feedback</td>
<td>○</td>
</tr>
<tr>
<td>Local Teaching</td>
<td>○</td>
</tr>
</tbody>
</table>
Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were structures, processes and systems of accountability to operate a governance system designed to monitor the service and provide assurance. We were told the governance approach was being reviewed by the new chief executive to enhance what was already in place.

Each year the trust defined their quality improvement priorities through the development of a trust wide quality Improvement framework (QIF). The QIF was a tool to engage and communicate with staff and patients about transformation projects to improve the quality of care. The priorities were informed from information gathered from patient surveys, complaints and concerns, safety incidents and national and local quality initiatives.

At the time of inspection there was a subcommittee of the board, the quality committee, of which non-executive and executive directors were members. The named executive leads for quality were the medical director and the director of nursing and organisational development. The aim of the quality committee was to provide challenge and scrutiny to both operational and quality performance. A rolling programme of monitoring and review of progress was undertaken at each meeting of the quality committee against a broad range of indicators such as integrated performance report, access performance (including emergency department and referral to treatment), delayed transfers of care (DTOC), never events/ serious untoward incidents, complaints, emergency re-admissions, and clinical outcomes.

A quality governance steering group (QGSG) met monthly and reported to both the quality committee and the trust executive committee (TEC). We observed a QGSG meeting on 4 December 2018 chaired by the director of nursing and operational development. At the QGSG all divisions were represented, reported on progress for action plans and gave updates on key issues.

At the meeting a trust bacteraemia, incident and outbreak report was discussed. This included themes identified and learning. For example, for Norovirus/viral diarrhoea and vomiting there had been seven outbreaks in quarter two 2018/2019 of which four had learning noted such as the need for improved timeliness of sending specimens for assessment. There had been seven C. difficile cases attributed in the same period, four with learning such as the need to use the C. difficile care pathway and need for improved documentation. The infection prevention and control team was shortlisted for team of the year at the Infection Prevention Society Annual Awards in recognition of reductions in infection, with MRSA bloodstream infection down from 92 cases in 2005-06 to two in 2017-18 and Clostridium difficile from 741 to 34 cases.

We spoke with the consultant microbiologist with responsibility for infection prevention and control about antimicrobial stewardship who described a team of antimicrobial pharmacists to undertake data collection and to assess against trust policies for prescribing. There was a Smart phone app about antimicrobial treatment, followed by junior doctors whom contacted the on-call microbiologist if any concerns.
A serious incident scrutiny group reported to the QGSG to share learning, examples were presented of new cases and closures including any action taken.

There was an experience of care team covering support services, bereavement care, patient insight and voluntary services. The team provided updates to a wide range of trust governance groups and meetings; divisions were given summary packs each month highlighting trends around complaints and performance, with a quarterly deep dive into experience of care in the individual services for learning. An overall quarterly report was prepared for the QGSG, TEC and the quality committee.

There was a clinical effectiveness steering report for both the TEC and QGSG to update on the progress of clinical outcomes workstream detailing clinical departments and activities.

All wards and departments had undergone an internal clinical accreditation scheme to assess and improve the quality of the services provided on an annual basis. Various information was considered such as patient complaints and compliments which was presented to a senior clinical panel with patient representatives who completed an unannounced visit of the ward. Wards attaining accreditation were awarded with a certificate, which was presented to them by the director of nursing and organisational development.

Safeguarding was overseen by the director of nursing and operation development. There was not a dedicated doctor for adult safeguarding and the trust were considering this option however we were told all doctors were helpful and supportive. There was however a named doctor for mental capacity and deprivation of liberty safeguards. There was a children and an adult safeguarding team working closely together with the “think family” approach. There were quarterly divisional updates from the safeguarding team that included learning and audit outcomes for sharing at the QGSG and reported to the board as needed. The trust had identified areas of risk as safeguarding training for both adults and children, deprivation of liberty safeguards (DoLs) training, delays with national deprivation of liberty safeguards impacting on local processes and a local DoLs backlog in outcomes and CQC notifications. Training requirements had been reviewed against the intercollegiate document for children and adults. Staff were trained as needed to level 4 and we were told the guidance for level 3 and above training requirements was due for roll out in January 2019. A new training package for mental capacity and DoLs commenced in November 2018 and was available on the trust internet for staff. The safeguarding team held a learning event in November 2018 to raise awareness to staff on current national and local policies and guidelines including on female genital mutilation, mental capacity, exploitation, neglect and domestic abuse.

Since 2014, the trust had established an integrated medical examiner group (IMEG) to review all adult inpatient deaths. The policy, updated in 2018, described a clear inclusive process for twice daily medical examiner reviews Monday to Fridays for which all deaths had to be presented no later than the day following the death. In line with guidance child, maternity and learning disability patient deaths were reviewed and deaths in the community within 30 days of discharge were also reviewed. There was a policy to support doctors in the completion of medical certificates for cause of death and determining when a death should be reported to the coroner. Deaths requiring further internal review or investigation were escalated to the mortality review group and significant incident scrutiny group. IMEG reported quarterly to the quality committee and trust board. The IMEG gave examples of organisational wide learning shared through bulletins.

There was established governance for end of life care (EoLC) with an EoLC strategy group attended led by a NED, the group had over the last year focused on how to improve the holistic
approach and how to use the bereavement data to optimise care. We were told how the trust invited family members to reflect on their experience of the trust services through the end of life care stages of a loved one.

Governance of medicines management was taken seriously by the trust. The medicines team fed into the trust governance structures, primarily via the medicines safety committee, drugs committee, quality committee and patient safety group. The Controlled Drugs Accountable Officer role held by the chief pharmacist reported directly to the trust board. Medicines incidents were reviewed at a monthly medicines safety committee. The Medicines Safety Officer role was trust-wide and well embedded. Staff were encouraged to report incidents involving medicines, and there was an open no-blame culture around incident reporting supported by the Medicines Safety Officer.

NEDs provided the board with a healthy challenge on governance, risks and actions to be taken. The trust had seen increasing number of mental health patients who had not always received a rapid response from the local mental health trust. To reduce risks a mental health board was created and a psychiatric liaison appointed. We spoke to the director of nursing and operational development as lead for mental health, who acknowledged the challenges of patients presenting with mental health needed further review to support and improve competency of staff in some areas who hadn't been trained in mental health.

There were specialist groups – fire advisors, occupational health, security emergency planning, estates, staff moving and handling, divisional health and safety representatives, who each submitted quarterly reports to the corporate health and safety committee which were supported by a non-executive director. The groups then fed into the QGSG, with an assurance report to TEC for the board. Health and safety was taken seriously and information and training was readily available for staff. There were 30 health and safety risks on the risk registers held across the trusts departments and divisions. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) incidents had reduced in number to currently 30 and we were told this indicated the safety culture was strong.

We spoke with the director of estates who confirmed there was governance of the trust sites although not a specific estates strategy. The trust had begun a programme of refurbishment and the priority had been maintenance. However, there trust acknowledged the aging estates for fire, water, electricity, and ventilation maintenance; we were told that all maintenance required for safety and statutory requirements was undertaken.

There was a dedicated lead for infection prevention and control who linked with estates to include the oversight of water and ventilation safety and involvement in any newbuild or refurbishment. In response to identified risks, work was underway on a £5m project to build a new Children’s Emergency Department. There was a rolling programme of refurbishment to wards and theatres. Window and lighting upgrades had been scheduled.

The trust held public and private board meetings. We reviewed the trust board papers 29 November 2018; the open session minutes were brief and summarised therefore the degree of challenge and debate could not be gauged. We were told by a NED that such challenge and debate did take place but was not reflected in the recording of the meetings. The board papers were of various standards, the integrated performance report and headline survey was well presented with explicit assurance however there was an inconsistent cover sheet by way of content and quality. For the trust board closed session, the chief executive report focussed on internal and external relationships and areas that could have been included in the open session such as serious incident reviews.
Board Assurance Framework

There were effective arrangements to ensure the trust executive team discharged their specific powers and duties. The board of directors had various committees reporting to it, including: charitable funds, remuneration and terms of service, finance and performance, quality assurance, workforce and education as well as the risk and audit committee. The board was informed about performance, governance and assurance. This included a look at operational performance, safety and quality of care. The trust board was provided with information regarding financial performance. This included the current performance, income and activity, with progress on the cost improvement plan, cash, and capital expenditure.

We reviewed the board assurance framework (BAF) provided by the trust; there were action plan dates. Descriptions were very brief and it was unclear how this BAF gave assurance to the board. The recently appointed associate director of corporate affairs had identified there was an opportunity for some changes to the style of the BAF.

The trust provided their Board Assurance Framework, which detailed 14 strategic objectives within each and accompanying risks. A summary of these is below.

- Priority 1: Create better flow for patients through the Hospital by implementing the SAFER care bundle and reducing the number of delayed transfers of care.
- Priority 2: Implement the Quality Improvement Strategy.
- Priority 3: Maintain momentum on IT, deliver the global digital excellence strategy.
- Priority 4: Ensure we deliver value based healthcare (VBHC) and change clinical pathways for patients, ensuring they are research led and evidence based.
- Priority 5: Education – agree the new education plan for nurses and therapists.
- Priority 6: Implement our Hospital without Walls by developing relationships, and services, for Wessex and beyond.
- Priority 7: Implement our Hospital without Walls by developing relationships, and services, for Hampshire and the IOW.
- Priority 8: Maintain focus on operational excellence and delivering good services for patients balancing the operational and the strategic.
- Priority 9: Deliver Quality Improvement Framework priorities on quality and safety and meet regulatory requirements.
- Priority 10: Significantly refurbish and expand the ageing hospital estate, whilst maintaining the short term operational impact.
- Priority 11: Make UHS an employer of choice for each skill set.
- Priority 12: Deliver the financial plan.
- Priority 13: Appoint, induct and support a new Chief Executive and Non-Executive Directors.
- Priority 14: Continue to enhance our reputation and achievements in research and innovation as one of the country’s leading centres translating basic discoveries into the clinic for patient benefit.

(Source: Trust Board Assurance Framework – P106 - September 2018)
Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The associate director of corporate affairs had identified there was an opportunity for some changes to risk management systems and processes. There was a strong risk appetite and a new risk strategy and risk policy had been presented to board for approval.

The trust recognised and reported in 2017/2018 that key issues and risks had included a failure to deliver some national access targets. Operational risks had been identified across a number of services/specialties linking to issues around increasing referrals, system capacity and delayed transfers of care. The trust had implemented daily reviews to assess system capacity and escalation requirements aligning capacity plans with the wider system, developing plans to reduce length of stay with strong clinical leadership and oversight and working with local health and social care partners to reduce delayed transfers of care.

Each service had their own risk register, for example in the pharmacy service a risk register was in place which was reviewed at regular intervals. All risks were assigned a review date and appropriate actions were taken to mitigate known risks. Processes were in place to monitor the performance and quality of the pharmacy service, and this was reviewed by the trust executive team.

Risks had been identified in 2018 in respect of delays for patients needing ophthalmology services. The trust and key stakeholders NHS England and clinical commissioning groups informed us of the concerns for patient waiting times for follow up appointments and incidences where harm had happened to patients as a result. Trust data showed 51% of patients being seen within 13 weeks, below the target 70%.

Following an article in a health publication in October 2018 the trust made a press statement about the delays and in summary reported the appointment backlog having been a growing problem which, in January 2018, affected 2,500 patients with diabetes and 4,500 glaucoma patients. Stating recruitment issues combined with a larger volume of patients requiring treatment – 5% more every year – had led to capacity issues for the delays in follow-up. No patient had died because of the lack of follow-up; however, 38 patients have seen their conditions worsen as a result. All patients had been risk-assessed to ensure those at increased risk were being seen sooner. All patients had been written to about delays.

We had also been informed by the trust that the follow-up ratio was above the national average and it was more likely to have a higher proportion of patients on pathways that required long term care. The trust saw relatively few patients for consideration of cataract surgery due to a substantial NHS cataract service commissioned from another local provider.

There had been three Never Events for ophthalmology, one in 2017. The second was in July 2018 where a procedure was undertaken on the wrong eye. It was concluded the patient did not sustain harm to the incorrect eye. The third occurred on 7 December 2018 with an incorrect strength of lens used to correct vision. The investigation was incomplete at the time of inspection.

The trust had consulted with the Royal College of Ophthalmology, had appointed a new consultant and had an action plan for resolution of the ophthalmology challenges effecting patient care.

There was an increased resilience as the trust had been an earlier adopter of seven day working and we were informed of the value this had added to patient outcomes during out of hours. It was
recognised not all areas were at the seven-day level however areas such as cardiology for chest pain and stroke care had been successful.

The trust had systems to identify learning from incidents, complaints and safeguarding alerts and to make improvements. In November 2018 at an engagement meeting the trust informed us they had reviewed the validation process of serious incidents to be more efficient and reduce a backlog. On inspection we reviewed six serious incident reports; all were well written, timely and covered the key principles expected with appropriate action plans and learning for improvement.

The trust understood its risks in terms of business continuity and planned for major incidents. There was a major incident response plan, which set out its responsibilities and roles in the event of an incident. NHS England required trusts to have suitable and up to date plans when faced with disruptions, but recognised these needed to be proportionate. Disruptions could be, for example, from severe weather, failure of systems or power, or an outbreak of an infectious disease. On 28 November 2018 the trust needed to invoke the major incident plan ensuring the safety of patients already admitted to the trust hospitals; following a power failure resulting in 26 ambulances diverted to neighbouring hospitals and 99 planned operations, as well as many outpatient appointments being cancelled. The next board meeting due on 31 January 2019 was to consider the incident and it was noted that an external review had been requested that would focus on the physical cause of what had happened and the organisation’s response to it. It was noted by the leadership team that all staff had responded extremely well and that the interaction between staff and patients had been positive.

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£761.9m</td>
<td>£806.3m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£20.4m</td>
<td>£41.2m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£741.4m</td>
<td>£765.2m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£16.2m</td>
<td>£27.1m</td>
</tr>
</tbody>
</table>

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

Trust corporate risk register

The trust provided documents detailing their six highest profile risks. Each of these have a current risk score of 20 or higher. We received an updated action plan for the ophthalmology delays. On inspection of the emergency department we saw that action had been taken towards addressing the risks in the emergency department and that meetings were held with the chief executive to review performance of that department.
<table>
<thead>
<tr>
<th>opened</th>
<th>score (current)</th>
<th>level (target)</th>
<th>review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>23/02/2017</td>
<td>20</td>
<td>1-3</td>
<td>17/09/2018</td>
</tr>
<tr>
<td>2143</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delivery of Endoscopy Service:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Workforce - staffing levels are not at budgeted levels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ineffective booking office processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Increased demand for complex and therapeutic endoscopy procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Increased demand for planned endoscopy procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Insufficient capacity for decontamination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Clinical budgets not funded for 7 working days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. ISTC Service - lack of robust booking/reporting process for patients referred to ISTC.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13/05/2015</td>
<td>25</td>
<td>1-3</td>
<td>12/09/2018</td>
</tr>
<tr>
<td>1939</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficient appointment capacity for all ophthalmology sub-specialities to accommodate the numbers of patients requiring follow up outpatient appointments including urgent follow up appointments. Applicable to all specialties. Glaucoma is the highest risk group due to the volume of patients. Patient safety root cause analysis investigations have been commissioned as patients in 2 separate cohorts (Diabetes and Glaucoma) have come to significant harm due to delays in accessing FU appointments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/01/2015</td>
<td>20</td>
<td>4-6</td>
<td>13/09/2018</td>
</tr>
<tr>
<td>1891</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency plastics provision for MTC patients: No provision for out of hours on site (UHS) emergency plastic surgery. This is particularly relevant as UHS is one of only two Major Trauma Centres in the UK without in-Trust plastics service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16/11/2007</td>
<td>20</td>
<td>4-6</td>
<td>17/09/2018</td>
</tr>
<tr>
<td>412</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to achieve ED Emergency Access Target Failure to achieve agreed Emergency Department (ED) monthly performance against 4 hour target (as</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
set by Clinical Commissioning Groups CCGs)

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>Score</th>
<th>Type</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/05/2009</td>
<td>824</td>
<td>ED Capacity - Pitstop and Majors The inability to access a suitable environment within the ED could impact on patient experience, outcome and at times, be a safety concern.</td>
<td>20</td>
<td>4-6</td>
<td>17/09/2018</td>
</tr>
<tr>
<td>18/08/2009</td>
<td>871</td>
<td>Violence and Aggression within ED Staff/patients/relatives/security staff in ED are exposed to a high level of violence and aggression from other patients, relatives and friends due to their patient group. This has further increased due to out of hours mental health services being unable to meet increase in demand along with a change in Police practices relating to Section 136.</td>
<td>20</td>
<td>4-6</td>
<td>17/09/2018</td>
</tr>
<tr>
<td>10/08/2017</td>
<td>2176</td>
<td>ED flow impacting on resus capacity On increasing numbers of occasions flow out of resus is delayed and this impacts on the availability of resuscitation beds and patient care. Patients are staying longer in resus and not being transferred to an appropriate destination elsewhere in the Trust. One patient remained in resus for 9 1/2 hours on one occasion and another for 11 hours with poor outcomes.</td>
<td>20</td>
<td>4-6</td>
<td>17/09/2018</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register)

There were other risks of note such as we observed with the director of nursing and organisational development the ophthalmology outpatient’s clinic and found the space was very congested with full waiting areas and lots of people seen bumping into each other as they moved around. The environment needed review to improve the patient experience.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The information manager provided reports on performance across a range of information each month and each division had their own lead analyst. Information was available on dashboards for clinicians and managers according to their roles. Data quality teams provided training about data quality and audit compliance of data collection. Information governance audits demonstrated the need to develop standard operating procedures and for the team to provide back up and support...
to improve consistency across the trust. The team were at the time of inspection looking at how
telephone clinics were recorded.

The informatics risk register was reviewed in management meetings every two months. Risks
included data quality for billing, data loss, cyber security, electronic prescribing interfaces. We
were told there was great interest in digital services and a challenge being the need for more
digital input into the training of clinicians.

At the inspection we raised with the senior leaders as well as the information manager that we had
been told about clinical records which had not been locked, as clinical records had not been saved
in a surgeons operating records. We had been told the system was supposed to lock all records
once they had been entered. We were told clinicians had different practices and some scanned
paper records into the electronic patient record and other made a direct entry. As a result of
raising this, the trust investigated the issue.

There was an electronic prescribing system used in inpatient areas. A suite of reports was
available to provide information on the quality and safety of prescribing, for example delayed and
omitted doses, medicines reconciliation and venous thromboembolism prophylaxis prescribing.
The trust was to launch an updated version of their electronic prescribing system in Feb 2019, to
allow the inpatient prescribing system to interphase with the system used in the emergency
department. Patient discharge information was sent electronically to the community pharmacy.

An improvement was made for patient safety for accurately identify patients for blood testing at the
bed side following incidents occurring such as the wrong forms being used. The change
implemented was the ability to electronically scan a patient wrist band when taking blood, which
identified the correct patient and the correct blood test.

There had been effective preparation for the information governance changes across the trust,
including how to manage any breaches. The trust had prepared for the implementation of the
General Data Protection Regulations (GDPR). Where there had been information governance
breaches these had been dealt with according to policy keeping the patient as the focus. There
was a health records and scanning bureau for all records to be kept on the electronic system.

A survey was undertaken between November 2018 to January 2019 to assess staff knowledge of
data protection, personal information and information governance. The staff completed eLearning
and the board received training as a group and were receptive to the importance of the subjects
covered. The risks were: data being held on paper, the inability to audit all data across various IT
systems used and the request for information sharing such as between consultants and
universities.

There was a Global digital programme manager, and the trust was recognised as one of 16

An example of the benefit for staff and patients was through the medical patient records (My
medical record) being accessible to patients and promoting supportive management of long term
conditions. This included prostate cancer, patients used to have monitoring by blood tests, wait for
results to go to clinician, then wait for an appointment. With access to My medical record, patients
could get results the afternoon after the test was taken, and could consult remotely with clinicians
if any concerns. There were education workshops for patients, to explain what the results meant
promoting self-management and only those patients that required a clinical appointment had one.
My medical records had a clinical tracker to ensure patients received the right care and treatment
dependant on their result – improving consistency and adherence to national guidelines and
reducing the risk of mistakes and missed processes. Processes for auditing records were in place and followed. Advice and support had been offered to other local trusts to implement same system.

We saw the use of electronic white boards introduced for improving patient safety as featured in professional journals. The touchscreen technology displayed information taken directly from a patient’s electronic record, including clinical alerts such as existing medical conditions, length of admission and predicted discharge date. It also acted as a tracking system to identify what was preventing discharge when patients were medically fit to leave hospital.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust made sure it included and communicated effectively with patients, staff, the public, and local organisations.

Staff felt engaged with through team meetings, and the senior leadership team had regular interactions with line managers. For instance, there were regular manager meetings, a staff survey, team briefs and chief executive bulletins. Staff informed us the professional leads fed learning back to the front-line teams through local governance groups and team meetings. Leaders were visible in the main hospital site and the director of nursing and organisational development presented staff awards and wrote letters of congratulations such as for low infection rates. There were limited ward visits by non-executives and governors.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. There were plans described of a Wessex system wide collaborative bank to address workforce issues.

The chief pharmacist held the role of Controlled Drugs Accountable Officer (CDAO) and attended the regional controlled drugs local intelligence network (CD-LIN). The trust shared information with the regional CDAO and the CD-LIN via quarterly paper-based reports. There are effective links with the local area prescribing committee which meet monthly with representation from local hospitals, other trusts, CCGs and general practice. The chief pharmacist linked with local chief pharmacists.

There was an active and visible ward based medicines team comprised of pharmacists and technicians. Staff told us this was appreciated and made it easy to access timely medicines related information. Patients and carers were provided with a discharge helpline which allowed people to contact the pharmacy team with any concerns or questions about their medicines.

It was important to the trust to hear the voice of all parts of the community it served; the equality and diversity lead told us the trust had been involved in some community groups and the new strategy would see this develop further.

People over the age of 16 year were encouraged to become a member of the trust to help support and know more about the work taking place across the services. There were geographical areas identified to ensure a cross section of the trust population was represented, including Southampton City, Isle of Wight, New Forest, Eastleigh, Test Valley and the rest of England and Wales.
People were also encouraged to become volunteers for the trust and there were at least 859 volunteers in October 2018, who worked at the hospitals and were involved with a wide range of activities including hospital radio, patient support and chaplaincy and spiritual care.

Patient lunches were another example of engagement with an opportunity for patients to give feedback about the service received during the hospital stay. These were confidential discussions which included patients previously treated by the same service, chaired by the chief executive.

The trust had advertised on their website two new engagement groups to help improve children and young people’s services. Membership to the groups was open to any person who may use the services of Southampton Children’s Hospital or University Hospital Southampton as a young patient or their parents and guardians.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There was a strong culture of continuous improvement in the trust working with patients and external partners.

There was an established quality improvement team supporting local teams in developments and there were recorded in an accessible way for all staff. Some staff had received specific training to become quality improvement ambassadors. There were about 40 projects on the quality improvement registry each aiming to improve the patient outcomes such as reducing the use of urinary catheters, one stop pre-assessment appointments for pregnant women and reducing the need for general anaesthetic for children having an MRI scan through play. The trust was proud of the cancer pathways redesign with a reduction from 22 median days to 8 median days for treatment.

The trust had launched a specialist emergency assessment unit for older patients. Around 25 people over 80 presented to Southampton General Hospital with medical emergencies every 24 hours and, would have been assessed and treated in the emergency department prior to admission to a ward. However, improvements were made with the introduction of a new frailty unit, based in acute medicine, where patients received rapid assessment by a team led by consultant geriatricians. The five-bed facility at the time of inspection operated for eight hours a day but was expected to extend to 12 hours a day over the next few months. We were told patients were identified as soon as they presented to hospital and, rather than spending time on a trolley in the emergency department, they were taken to a dedicated unit described as quieter and less disruptive environment. Following assessment by a team of experts which included a consultant geriatrician, patients were given a clear plan with the aim of facilitating a smooth admission and minimising their length of stay. This innovation was expected to assist also with the winter demands across the medical services. As part of the initiative, the trust worked in partnership with clinical commissioning groups, other local NHS trusts and councils to ensure the development aided improvements in access to community care.

The trust had a strategy for the avoidance of overnight moves. Whilst there were 60 in October 2018 this was reduced to 20 in November 2018 due to the flow-pull model where patients, on the acute medical unit, had a ward identified for admission and the wards called for the patients as
soon as the bed was ready. This was managed through the electronic white boards in real time meaning each clinician could see which ward their patient would be going to. The trust winter plan included dedicated extra medical beds (taken from Orthopaedics) so patients would not be outliers and would have better care under a medicines model.

The development of a Medicine for older people (MOP) patients and carers hub had been designed with the help of charitable donations for 2018/2019 with changes planned for layout of inpatient care facilities to include a dementia café and activity centre.

A comic had been developed to capture the interest of patients such as for those with diabetes raising health awareness. There have been two publications developed jointly by a doctor at this trust, along with another doctor from a local acute NHS trust in collaboration with patients.

To support patients with a learning disability the trust had part funded learning disability qualified nurses along with commissioners and had worked to ensure patients had a This is Me document known as a passport explaining their personal history and potential care needs.

Research studies and clinical trials were well established at the trust and aimed to improve understanding of health better, and to develop new ways of treating or managing conditions. Patients and those coping with health conditions were offered access to trials of the latest treatments relevant to them, and involved otherwise healthy people in research that underpinned treatments. We were told 1000 research studies were being conducted across the trust at any given time. There was a clear link between research and care on in the clinical areas for medical, nursing AHP research. The trust had been keen to align to the sustainability and transformation partnerships (STP) priorities such as for the Wessex Cancer Alliance.

An example of learning and innovation came from researchers at the trust and in the USA who created an app that “can predict a child’s risk of asthma through six simple yes or no questions – and without the need for blood tests.” Known as the Personalised Asthma Risk Score (PARS), it was explained as having the potential to help prevent the condition in some children by identifying those at moderate to high risk who could benefit from interventions.

Southampton Children’s Hospital became the first in the country to offer young patients the opportunity to obtain the Duke of Edinburgh’s Award as they transition to adult services to assist with improving self-confidence and self-reliance. The inclusion in this award was the result of the passion of trust doctors to support young people to have better opportunities despite long term health conditions. The award, which was created by Prince Philip in 1956, recognises teenagers and young adults who develop life skills through a series of activities and challenges.

The Vulnerable adults support team (VAST) won a Nursing Times award in November 2018 for a pioneering initiative to provide better support around the underlying causes of physical and mental health crises in the emergency department. The team included support staff who worked alongside emergency department clinicians and mental health professionals to manage issues such as domestic abuse, homelessness and substance use. VAST practitioners managed the psychological and social care needs of around 120 patients a month including screening, risk assessment, information giving, signposting, referral and safeguarding. As part of developments for vulnerable patients, funding was secured for two specialist assessment rooms for patients with disturbed behaviour due to mental illness or substance use.

**Complaints process overview**
There was clear learning from complaints and patient feedback however there were delays with potential for missed opportunities for early resolution by the trust.

The overall volume of complaints and concerns had continued to increase year on year in part in line with activity levels. The trust said they had struggled to meet the 35 working days target for 66% complaints to be closed. At the end of quarter two the achievement had been 55%. It was recorded that the biggest contributing factor to complaint breaches was a delay in statements from staff. To improve the performance the trust complaints team had attended divisional and care group governance meetings and development days for Band 6 and Band 7 staff to explain the process and remind staff of the importance of timeliness in responding.

The patient support services had limited space for the access and privacy for patients to raise concerns. Patient support services had commenced a 12-month quality improvement project regarding the trusts complaints process, to include working with patients and staff and other stakeholders.

Most complaint responses were signed off by the chief executive if available or by another member of the leadership team. We reviewed several complaint responses to patients which were very lengthy and complex to read at times. We were also told the way patients received a response would be changed following a review.

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>5 days</td>
<td>Not reported</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>35 working days</td>
<td>67%</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>379</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

**Number of complaints made to the trust**

The trust received 480 complaints from September 2017 to August 2018. Surgery received the most complaints with 111.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>111</td>
<td>23.1%</td>
</tr>
<tr>
<td>Medical care</td>
<td>101</td>
<td>21.0%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>87</td>
<td>18.1%</td>
</tr>
<tr>
<td>Urgent &amp; Emergency</td>
<td>65</td>
<td>13.5%</td>
</tr>
</tbody>
</table>
Services for children and young people | 44 | 9.2%
Maternity | 26 | 5.4%
Diagnostics | 16 | 3.3%
Trust wide | 15 | 3.1%
Critical Care | 8 | 1.7%
Gynaecology | 7 | 1.5%

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

Compliments

From September 2017 to August 2018, the trust received a total of 68 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>AC - Maternity</td>
<td>4</td>
<td>5.9%</td>
</tr>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>41</td>
<td>60.3%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>2</td>
<td>2.9%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>5</td>
<td>7.4%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>10</td>
<td>14.7%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

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

Accreditations

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

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

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Medical Care</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>N/A</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Surgery</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Accreditation Scheme</th>
<th>Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</td>
<td>Medical Care</td>
</tr>
<tr>
<td>Commission for the Accreditation of Rehabilitation Facilities (CARF)</td>
<td>Medical Care</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>Medical Care</td>
</tr>
<tr>
<td>Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)</td>
<td>Medical Care</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Medical Care</td>
</tr>
<tr>
<td>AIMS - WA (Working Age Units)</td>
<td>N/A</td>
</tr>
<tr>
<td>AIMS - PICU (Psychiatric Intensive Care Units)</td>
<td>N/A</td>
</tr>
<tr>
<td>AIMS - AT (Assessment and triage wards)</td>
<td>N/A</td>
</tr>
<tr>
<td>AIMS - OP (Wards for older people)</td>
<td>N/A</td>
</tr>
<tr>
<td>AIMS - Rehab (Rehabilitation wards)</td>
<td>N/A</td>
</tr>
<tr>
<td>Quality Network for Inpatient Learning Disability Services (QNLD)</td>
<td>N/A</td>
</tr>
<tr>
<td>Quality Network for Inpatient CAMHS (QNIC)</td>
<td>N/A</td>
</tr>
<tr>
<td>Quality Network for Community CAMHS (QNCC)</td>
<td>N/A</td>
</tr>
<tr>
<td>Quality Network for Perinatal Mental Health Services (QNPMH)</td>
<td>N/A</td>
</tr>
<tr>
<td>ECT Accreditation Scheme (ECTAS)</td>
<td>N/A</td>
</tr>
<tr>
<td>Psychiatric Liaison Accreditation Network (PLAN)</td>
<td>N/A</td>
</tr>
<tr>
<td>Memory Services National Accreditation Programme (MSNAP)</td>
<td>N/A</td>
</tr>
<tr>
<td>Accreditation for Psychological Therapies Services (APPTS)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

Outpatients (Royal South Hants Hospital)

Facts and data about this service

The University Hospital Southampton NHS Foundation Trust provides outpatient appointments for adults for a wide range of medical, surgical and ophthalmology specialities. They provide services at the Southampton General Hospital (SGH), Royal South Hants Hospital (RSH), the Princess Anne Hospital and peripheral clinics at Queen Alexandra Hospital, Lymington New Forest Hospital and at the Countess Mountbatten House. However, the majority of adult outpatient clinics are located at the Southampton General Hospital and the Royal South Hants Hospital. Each year this trust facilitates over 900,000 outpatient appointments.

Children’s outpatient services and maternity outpatient services are not reported in this report. They would be reported under the children and young people core service and the maternity core service reports. However, some children were seen in regular outpatient clinics dependent on speciality including Ear, Nose and Throat (ENT) and ophthalmology. Maternity outpatient clinics are located at the Princess Anne maternity Hospital.

The trust is a regional centre for many specialities including cancer care, cystic fibrosis and allergy and immunology.

The trust provides consultant, nurse and allied healthcare professional-led outpatient clinics. Outpatient clinics are mainly coordinated by the Patient Service Centre.
The trust has four Divisions; Division A, Division B, Division C and Division D. The Divisions are further split up into medical speciality Care Groups. Outpatient departments were managed in the Care Group to which the medical speciality belonged.

The Patient Service Centre (PSC) is part of the Trust Headquarters (THQ) and sits in the Chief Operating Officer (COO) Directorate. The PSC is located at the Southampton General Hospital.

Medical specialities were run out of Southampton General Hospital but some specialities held their outpatient clinics at the Royal South Hants Hospital.

During this inspection we visited the Southampton General Hospital and the Royal South Hants Hospital.
We inspected the following outpatient departments at the Southampton General Hospital:
Ophthalmology
Chemotherapy
Oral and Maxillofacial
Pathology and Phlebotomy
Dietetics
Neurology
Cystic Fibrosis
Respiratory
Allergy and Immunology
Medical care
Cardiovascular thoracic
Oncology
Physiotherapy
Occupational therapy
Victoria House - Rheumatology and Managed Care
Patient Service Centre

and the following outpatient departments at the Royal South Hants department:
Trauma and Orthopaedics
Dermatology
ENT

Inspection findings from the outpatient clinics visited at the Royal South Hants Hospital are reported in this report and inspection findings from the clinics visited at the Southampton General Hospital, inspected at the same time, are reported in a different report. All outpatient services are managed and overseen by the surgical and medical specialities of the University Hospital Southampton NHS Foundation trust, therefore much of the information found in the separate RSH and SGH evidence appendixes are interlinked.

During the inspection we spoke with 22 patients and relatives, 88 members of staff including administration staff, managers, doctors, nurses, allied healthcare professionals and healthcare assistants across the two sites. We observed care being provided, looked at patient waiting areas and clinical environments, policies and procedures and information provided by the trust both before and after the inspection.
Total number of first and follow up appointments compared to England

The trust had 707,026 first and follow up outpatient appointments from July 2017 to June 2018. 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, a total for the trust and the total for England, from July 2017 to June 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southampton General Hospital</td>
<td>789,342</td>
</tr>
<tr>
<td>Royal South Hants Hospital</td>
<td>120,049</td>
</tr>
<tr>
<td>Princess Anne Hospital</td>
<td>101,726</td>
</tr>
<tr>
<td>Lymington Hospital (Peripheral Clinic)</td>
<td>24,698</td>
</tr>
<tr>
<td>Queen Alexandra Hospital Peripheral Clinic</td>
<td>14,338</td>
</tr>
<tr>
<td>This Trust</td>
<td>1,088,389</td>
</tr>
</tbody>
</table>
Type of appointments:

The chart below shows the percentage breakdown of the type of outpatient appointments from July 2017 to June 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at University Hospital Southampton NHS Foundation Trust from July 2017 to June 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff. Nursing staff compliance with mandatory training courses was equal to or above the trusts compliance rate of 85%. However, medical staff’s compliance with the majority of training courses was low.

Mandatory training was provided in different formats including as part of the induction process for new starters, face to face classroom training and e-learning. Staff told us training was easy to access via ward computers. Nursing and allied health professionals we spoke with said that time was given to them to complete their training.

Staff we spoke with knew how to access mandatory training and explained how the hospital computer system would flag up any outstanding training or updates that were required.

Senior staff explained how they monitored their staff’s mandatory training compliance and would email staff if training was required. This was confirmed by team members we spoke with.
There was no mandatory training in the management/understanding of patients living with mental health conditions, learning disabilities, autism or dementia. This meant that staff were not routinely trained in the awareness of meeting the potential needs of complex patients. The Trust told us they had run a learning disability awareness training session for 60 members of staff working at the trust and this included some outpatient clinical staff.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018, at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>69</td>
<td>69</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>69</td>
<td>69</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>69</td>
<td>69</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>67</td>
<td>69</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>64</td>
<td>69</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>43</td>
<td>49</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>60</td>
<td>69</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>59</td>
<td>69</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>52</td>
<td>61</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for nine of the nine mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018, at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>7</td>
<td>9</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>6</td>
<td>9</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>5</td>
<td>9</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>9</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>4</td>
<td>9</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>4</td>
<td>9</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met two of the eight 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. Staff had training on how to recognise and report abuse and they knew how to apply it. However, medical staff compliance with safeguarding training was low.

Clinical staff understood how to recognise and report a safeguarding concern. Staff we spoke with told us they would talk their concern through with another colleague then escalate their concern to the safeguarding lead, matron or nurse in charge.

We saw that information on safeguarding from abuse was displayed in waiting areas. Female genital mutilation (FGM) was included in the Safeguarding training.

The service displayed information in outpatient reception areas on how to request a chaperone. This informed patients that a chaperone of their own gender was available to accompany them during their appointment on request.

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from September 2017 to September 2018, at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>62</td>
<td>69</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>45</td>
<td>57</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018, at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>5</td>
<td>9</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>3</td>
<td>9</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for neither of the two safeguarding training modules for which medical staff were eligible.

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

Cleanliness, infection control and hygiene

Not all areas of the service controlled infection risk well and there was no consistent approach to infection control and prevention in the outpatient departments.
Not all areas of outpatient services were clean. The trust employed an external contractor to clean the premises and we were told by staff that the standard and frequency of cleaning was an issue. During the inspection we saw and were told about areas that were not clean. For example, unclean toilets at the Royal South Hants Hospital.

We saw no cleaning schedules displayed in outpatient departments.

Staff from the orthopaedics service at the Royal South Hants Hospital told us they had taken to cleaning the toilets themselves as although they had escalated problems with the contract cleaners, the issue with unclean toilets remained. We were told the cleaning of some outpatient departments occurred Monday to Friday between 4pm and 8pm.

During the inspection we asked outpatient departments if they carried out local infection control audits and post inspection we asked for data from these audits. From discussions during the inspection and from data provided post inspection we could see some measures were audited, for example clinical cleanliness and hand hygiene. However, there seemed to be no consistent approach to audits in the outpatient departments, with each department auditing different things and using their own paperwork. There was also no consistent timeframe when audits should occur. We saw gaps in the reporting of information. Therefore, we were not assured there was a universal approach in the trust for the monitoring or reporting of infection control and prevention in the outpatient departments.

No information from infection control audits, such as hand hygiene results were displayed in outpatient areas for patients to see. We were told by staff it had been decided to reduce the amount of information displayed in clinical areas. We were told by the trust there was a Trust de-cluttering strategy to reduce the amount of information displayed in clinical areas, with an agreed list of information to be displayed. This included the area’s infection prevention accreditation certificate and the corporate hygiene signs. We did not see this information displayed in the areas we visited.

Chairs in the outpatient departments we visited were covered in wipeable fabric. However, we did observe dusty chair frames and chairs with rips in their seat covering which could present as an infection risk.

During the inspection we asked staff working in the outpatient departments we visited if the trust’s infection control team carried out regular environmental and clinical practice infection control audits. We were told that walkabouts did happen but they were quite ad hoc. Post inspection we asked for information from the trust’s infection control team on environmental infection control audits. From the information provided it was seen the trust infection control team carried out spotlight reviews of environmental and clinical practice standards in clinical areas on a rolling program, with clinical outpatient areas being reviewed every two years. Due to the infrequency of external infection control audits, if infection control problems arose in the outpatient departments, it could take a while to be recognised and acted upon.

All staff we saw in outpatient areas were bare below the elbow in line with trust policy. This was to promote more effective hand hygiene by ensuring hands and wrists are fully exposed to the hand hygiene product and items that can become contaminated during work activities (e.g. long sleeves, jewellery) or have the potential to harbour micro-organisms were removed. Personal protective
equipment (PPE), such as gloves and aprons, were available for staff in all areas where it was necessary. We mostly saw staff using PPE appropriately.

Hand sanitiser gel was mostly available in outpatient areas.

We saw posters for staff and patients about the important of hand hygiene. However, each department displayed a different poster, this again highlighting there was no standardisation to the infection control management across the outpatient departments. In addition, as part of the Trust’s de-cluttering strategy, which had an agreed list of information that should be displayed in departments, there was an agreed corporate hand hygiene poster that should be displayed.

Equipment we looked at in the outpatient departments was mostly clean and free from dust. We saw the use of ‘I am clean’ stickers throughout the outpatient departments. Equipment was labelled and dated so staff knew the items were clean and ready for use.

Environment and equipment

Outpatient services were provided in designated clinical areas. Not all outpatient services had suitable premises. In general equipment was looked after well.

The trust for some specialities held their outpatient appointments at the Royal South Hants Hospital.

Most waiting areas in outpatient areas we visited during the inspection had enough seating for patients. However, some outpatient waiting areas were not suitable for the volume of patients attending. Outpatient nurses also told us clinics were running out of space.

Most departments had seating for bariatric patients. However, we saw limited seating with arms and high backs for the elderly and not all clinics had enough room to accommodate wheelchairs or mobility scooters.

In general equipment was looked after well by staff. We found equipment to be generally stored appropriately and neatly. Equipment consumables were in date and electrical equipment we looked at had evidence of electrical safety testing. We saw staff personal property in clinical areas, for example staff handbags and mobiles stored in the flammable gases cupboard of the orthopaedics department; this was a safety risk as not the intended use of the cupboard.

We inspected resuscitation equipment in all outpatient areas we visited. We found trolleys were locked and contained anti-tamper tags. We reviewed records and saw that daily checks were completed for the defibrillator and external equipment and weekly checks completed for the equipment in the draws. This showed a consistent and regular approach to safety checks.

Assessing and responding to patient risk

The trust were developing systems and procedures to assess, monitor and manage risks to patients.
Staff could tell us how they would respond if a patient became clinically unwell in an outpatient area. Staff would monitor them, check their vital signs and request emergency assistance from the medical emergency team and we were given examples by staff when this had happened. If a patient required hospital admission following review and treatment by the medical emergency team, transfer was arranged either to a ward or to the accident and emergency department depending on the nature of the patient’s illness.

There was limited use by clinical staff of the national early warning scores (NEWS) in the outpatient departments. NEWS is a chart used to quickly determine the degree of illness of a patient. It is based on six patient observations, breathing rate, amount of oxygen in the blood, blood pressure, heart rate, level of consciousness and temperature. It used to help recognise a patient whose condition is deteriorating. Even though NEWS was not regularly used we saw evidence that NEWS2, the updated version of NEWS which had recently been endorsed by NHS England and NHS Improvement for use in hospitals in England, was being explained to staff working in outpatients.

There was a clear process in outpatient departments to check the identity of the patient by using name, address and date of birth. We observed staff obtaining this information from patients that attended for appointments both when they checked in at the outpatient reception desks and before procedures occurred.

Not all waiting rooms in the outpatient departments were in sight of staff. This meant if a patient became unwell or needed urgent assistance, there was no one to raise the alarm. In addition, there were no emergency call bells in these waiting rooms.

Emergency equipment was available in the event of emergency. Clinical staff working in outpatients were required to complete mandatory basic life support (BLS) training. However, this mandatory training had not been completed by all members of staff, nursing staff had a 86% compliancy rate (above the trust target of 85%) and medical staff had a 44% compliancy rate.

Reception staff working in the outpatient departments told us that they had not completed basic life support training and was not mandatory for their role. When asked what they would do if they saw a patient become unwell in the waiting room they said they would alert a member of the clinical team.

We were told by staff working at the Royal South Hants hospital that the emergency call bell in the plaster room at the Southampton General hospital site was broken and if assistance was required they had to go into the nearby emergency department to raise the alarm. Management were aware of this and we were told it had been added to the risk register.

Standards for Invasive Procedures (NatSSIPs) were used in the trust. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs) such as taking biopsies, removing lesions and injections into eyes. However, it was unclear how embedded these procedures were with staff working in the outpatient departments. There had been a NEVER event (never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them) due to LocSSIPs procedures not being followed in July 2018. We reviewed the root cause analysis for this incident, which included a summary of the incident, the root cause and contributory factors and the main recommendations and specific learning required, which included further education of LocSSIPs.

During the inspection we spoke to senior staff working in the care groups, divisions and the
patient service centre, and were told there was now closer monitoring of referral to treatment time (RTT) and waiting times for follow up appointments in the outpatient services. This was because delays in appointments had been discovered which had resulted in harm to patients. Weekly and monthly meetings between operational staff in the specialities and the patient service centre now occurred and changes in how follow up appointments were entered and reviewed on the trust’s patient appointment booking system.

Nurse staffing

**Outpatient services had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

There are no agreed national guidelines as to what constitutes ‘safe’ nurse staffing levels in outpatient departments. Staffing levels and skill mix were planned on the number of clinics and patients attending.

Clinical services in outpatient departments were provided by outpatient nurses, clinical nurse specialists, healthcare assistants and other allied healthcare professionals.

At the time of our inspection in most outpatient departments, nursing staff met the needs of patients.

We found across outpatient departments bank and agency staff were rarely used.

We were told by senior operational staff working in the Division B directorate there were daily huddles by the Division B matrons and staffing problems would be discussed there. If staffing issues couldn’t be dealt with at a divisional level they would be taken to the daily trust-wide staffing meeting. Although we were told this meeting tended to focus on inpatient staffing issues rather than outpatient departments. Nursing staff tended to work in designated outpatient clinics in their specialities. Therefore, it was unlikely nurses would flex to provide cover for staff shortages in other outpatient clinics.

Vacancy rates

From September 2018 to August 2018, the trust reported no vacancy figures for nursing staff in outpatients.

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

Turnover rates

From September 2018 to August 2018, the trust reported a turnover rate of 8.8% in outpatients. This was lower than the trust target of 12.0%. A site breakdown is shown below however there were no figures for Royal South Hants Hospital:

Southampton General Hospital: 10.7%
Princess Anne Hospital: 0.0%

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

Sickness rates

From September 2018 to August 2018, the trust reported a sickness rate of 3.3% in outpatients. This was lower than the trust target of 3.4%. A site breakdown is shown below, however there were no figures for Royal South Hants Hospital:

- Lymington New Forest Hospital: 3.0%
- Princess Anne Hospital: 3.3%
- Southampton General Hospital: 3.5%

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

Bank and agency staff usage

From September 2017 to August 2018, Southampton General Hospital reported a bank and agency usage rate of 0.3% in outpatients. There were no figures for Royal South Hants Hospital.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Medical staffing

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

All medical staff worked and were managed by the division their medical speciality came under. Medical staff tended to cover both inpatient and outpatient activities.

Medical staffing levels and skill mix were planned on the number of clinics running within the outpatient departments on that day.

During the inspection staff reported good levels of consultant cover for outpatient clinics.

The trust has reported their staffing numbers for outpatients below for the period April 2018 to August 2018. There were no figures for Royal South Hants Hospital.

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southampton General Hospital (SGH)</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
From September 2018 to August 2018, Southampton General Hospital reported a vacancy rate of 3.0% for in outpatients. The trust did not provide vacancy rates for medical staff at the trusts other sites. There were no figures for Royal South Hants Hospital.

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

Turnover rates

From September 2017 to August 2018, South General Hospital reported a turnover rate of 0.0% in outpatients. This was lower than the trust target of 12.0%. There were no figures for Royal South Hants Hospital.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

Sickness rates

As at September 2017 to August 2018, Southampton General reported a sickness rate of 0.7% in outpatients. This was lower than the trust target of 3.4%. There were no figures for Royal South Hants Hospital.

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

Bank and locum staff usage

From September 2017 to August 2018, the trust reported no bank usage and locum usage in outpatients department.

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

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to staff providing care. However, records were not always stored securely in all outpatient areas.

A mixture of record management systems were used across outpatients to record patients’ care and treatment. The majority of outpatient services although using both paper and electronic systems were predominately paper light, meaning that electronic documentation was used rather than written notes.

The trust had migrated older patient documentation to the core electronic patient information system, meaning historic key information such as clinic letters, discharge summaries and pathology were also available to clinic staff electronically.

We were told by clinical staff for patient’s first appointments in clinics the full set of notes might be requested from the UHS health records library but for subsequent follow up appointments patient information would be obtained from the electronic computer system.
In the year before the inspection, the trust reported less than 1% of patients seen as outpatients did not have their full medical records available. We were told that if records were not available the medical clinician would be alerted and it would be their decision whether to postpone the appointment.

Following appointments, if there was any paper based patient information, this would be scanned by outpatient staff onto the electronic computer system so patient information was accessible to all clinical staff. Administrative staff in the chemotherapy department at Southampton General Hospital told us that paper notes were scanned after clinic. The paper notes would be kept two weeks before they were shredded into the confidential waste bin. Other departments including at the Royal South Hants hospital told us that clinic notes once scanned were immediately shredded. It was unknown if there was a trust policy in regard to the shredding of clinical paper notes.

We saw confidential waste was stored securely and disposed of appropriately.

During our inspection we saw that most outpatient departments had secure areas to store patient’s records. However, we did see paper notes used in clinics were left unattended and computers used to record patient information not locked in clinical areas. Clinical staff we spoke to told us that it was not always ideal where patient notes were kept during clinic but they had tried to mitigate to make sure patient confidentiality was maintained.

Staff in the patient service centre showed us the systems they used to manage appointments, records and collect clinical data. Electronic patient information was only available to authorised people, and computers and computer systems were password protected.

People with a learning disability or a mental health condition were flagged on the electronic patient record. This meant it was easy for staff to see if patients would require additional support whilst in clinic or needed to be scheduled at the beginning of a clinic if possible.

**Medicines**

Arrangements for managing medicines in the outpatient services were mostly suitable to ensure patients were kept safe from avoidable harm.

We saw most outpatient departments kept a low stock of drugs. Drug cupboards across the outpatient departments were locked with a registered nurse holding the keys. Medicines were stored securely and at the right temperature to remain effective. All drugs we checked were in date.

Medication fridges were locked when not in use and checked daily to make sure they were within the correct temperature range. Fridge temperature records we reviewed confirmed this. When we asked what would happen if fridges went out of range we were told by clinical staff that they would contact pharmacy for advice. We were given examples when this had happened and the actions that had occurred.

Staff we spoke with told us they had good links with the pharmacy department.

**Incidents**
The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

No figures were supplied by the trust pre-inspection in regard to the number of incidents reported in outpatient departments or the number of times duty of candour had been used in the outpatient departments.

Staff we spoke with in the outpatient departments had a good understanding of what to report as an incident. They all understood their responsibility to raise concerns, felt confident to report them and knew how to use the electronic reporting system. Staff gave examples of incidents they had reported. For example, when a letter was sent to the wrong patient in the physiology outpatient department and transport issues for patients in the rheumatology. Staff could describe learning from incidents. For example, we were told the trust no longer used window type envelopes for patient letters. This was because a group of letters meant for a GP surgery had been sent to the wrong address due to a different address being visible through the envelope window.

We were told by staff that incidents and learning from incidents was disseminated in various ways, for example, through daily huddles and meetings, formal monthly meetings, in newsletters and via email. We saw evidence that incidents were discussed at monthly care group meetings.

The care group to which the speciality belonged managed each outpatient department and feedback from incidents was generally kept within each care group. Therefore, we were unsure that learning from incidents was trust wide.

There was an electronic reporting system to allow staff to report incidents. This included a mandatory field on duty of candour. All staff we spoke with during the inspection were aware of and could explain the meaning of duty of candour.

Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

**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 October 2017 to September 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 22 serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from October 2017 to September 2018.

- Treatment delay: 19
- Confidential information leak/information governance breach: one
- Surgical/invasive procedure: one

(Source: Strategic Executive Information System (STEIS))

We reviewed a sample of the root cause analysis investigations for the serious incidents reported relating to outpatient areas and found that serious incidents were fully investigated in line with trust policy.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Clinical guidelines and policies were developed and reviewed in line with National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies and protocols were available on the hospital's intranet.

The trust had a clinical effectiveness (CE) team which reviewed the NICE website for updates in guidance. The CE team send this information to specific leads in the medical specialities to complete a gap analysis of their service compared to the new NICE guidance, and to incorporate the necessary changes into their working practices. The clinical effectiveness steering group
(CESG) audited to make sure that working practices have been changed to meet current guidance.

Post inspection the trust provided evidence of compliance audits with NICE guidelines in outpatients. We were given details of current audits being taken which included an audit to see if the assessment and management of patients referred to general neurology clinics with headaches were being diagnosed and managed in accordance with NICE guidelines and quality standards.

**Nutrition and hydration**

**Staff ensured patients had enough food and drink during their visit to outpatients.**

Water was available in all outpatients waiting areas we visited. Vending machines were situated in some outpatient clinics and at various points round the hospital. The hospital had a selection of places to eat in or purchase food and drink.

Patients receiving treatment in the rheumatology infusion unit were given hot drinks and sandwiches.

Although there was no formal process in place, staff would make sure patients got meals if they had very long delays waiting for their patient transport.

If required, outpatient patients could be referred to the trust’s diabetes or nutrition and dietetics inhouse services.

**Pain relief**

Patients were not routinely assessed for pain in the outpatient departments, as this was not generally a clinical risk. However, if needed, pain would be discussed by the consultant as part of the presenting condition and captured in the patient notes accordingly.

Clinical staff, if needed, would discuss simple pain medication and its use for patients at home and would give advice when to seek guidance.

There was an acute pain team in the trust which consisted of acute pain nurse specialists who patients could be referred and advise medical staff on pain relief. However, this service was mainly for inpatients after surgery based at the Southampton General Hospital. Since 2014 there had been no chronic pain management service run at the trust. If patients required this service they would be referred to a chronic pain management service run by another local trust.

**Patient outcomes**

**There was limited monitoring of the effectiveness of care and treatment in the outpatient service.**

Clinical audits were not routinely carried out across the trust outpatient services. Some
specialities had their own audit programmes, for example, the cystic fibrosis department at Southampton General Hospital.

The trust run an internal clinical accreditation scheme (CAS). This involved walkthroughs in clinical areas to assess certain outcomes, for example, how it appeared, looked, sounded and smelt. The scheme was originally for inpatients areas and had not included outpatient areas. However, outpatient departments were now involved in the CAS and we saw certificates in some of the outpatient departments saying they had reached quality standards. We were told by senior staff working in the outpatient departments, whilst implementing the clinical accreditation scheme, it was found there was no clinical dashboard for outpatients. Therefore, this had needed to be developed before outpatient departments could join the clinical accreditation scheme. We reviewed the outpatient clinical dashboard and saw that information on incidents, patient feedback, complaints, cleanliness and falls were included. However, not all outpatient departments were routinely collecting this information to enter into the dashboard. This meant there was not full oversight of patient outcomes across all specialties.

When we spoke with staff working in the outpatient departments we found they were very proud to now be included in the scheme and celebrated when the department had reached the standards required to get their CAS certificates.

**Follow-up to new rate**

Follow-up to new rate is a measurement of the number of follow-up appointments required after the initial appointment and is recorded as a ratio.

From July 2017 to June 2018,
- From July 2017 to October 2017 and in February 2018 the follow-up to new rate for Lymington Hospital (Peripheral Clinic) was lower than the England average. Lymington Hospital performance was similar to the England average from November 2017 to January 2018 and in May 2018. Lymington Hospital performance was higher than the England average in March 2018 and the latest month; June 2018.
- From July 2017 to January 2018 the follow-up to new rate for Queen Alexandra Hospital Peripheral Clinic was lower than the England average.
- The follow-up to new rate for Royal South Hants Hospital was higher than the England average. The trust performance was similar to the England average from February 2018 to May 2018.
- The trust performance dropped below the England average in the latest month; June 2018.
- The follow-up to new rate for Princess Anne Hospital was lower than the England average.
- The follow-up to new rate for Southampton General Hospital was higher than the England average.

**Follow-up to new rate, University Hospital Southampton NHS Foundation Trust.**
Competent staff

The service made sure staff were competent for their role. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor effectiveness of the service.

The trust had an induction programme for newly appointed staff. This included a one-day induction day which included a member of the executive team welcoming new starters to the trust. We spoke with staff who had recently joined the trust and had attended the induction day and were now working their way through the mandatory and statuary training modules required to work at the trust.

We saw that nurses, healthcare assistants and allied health professionals completed competency frameworks to ensure they were competent to carry out their role. There were general competencies and competencies specific to the medical speciality they were working in. We reviewed competency frameworks and found them to be detailed and completed correctly. We were told about extended competencies in many of the outpatient departments. These included, physiotherapists working in the orthopaedics department gaining additional competencies to assess hip and knee patients, nurses in the rheumatology department undertaking competency training to monitor early arthritis and ENT nursing staff passing competencies to use the equipment decontamination system in the department.

Staff we spoke with were positive about opportunities for further training with internal development being encouraged by their managers. We were given many examples across the outpatient departments of this, including, prescribing courses for staff in the orthoptic department.

We were given many examples by outpatient staff about training opportunities open to them. For example, staff were being funded to complete masters’ qualifications in the orthoptic department.
However, some staff told us that although there were training opportunities it was not always easy to take due to their workload pressures and the level of staffing in their departments.

Staff told us clinical supervision, mentoring and coaching was available to them.

Staff we spoke with had yearly appraisals with their managers. The trust appraisal form had recently been updated and was now linked to trust values. We were told by staff there was a clear structure for setting objectives and discussing and identifying training needs. During the inspection most staff could tell us when they last had an appraisal and when their next one was due. Several staff we spoke with had had an appraisal in the last two months.

**Appraisal rates**

From September 2017 to August 2018, 79.0% of staff within the outpatient departments at the trust received an appraisal compared to a trust target of 92.0%.

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>125</td>
<td>111</td>
<td>88.8%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>8</td>
<td>7</td>
<td>87.5%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>18</td>
<td>14</td>
<td>77.8%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>83</td>
<td>60</td>
<td>72.3%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>17</td>
<td>12</td>
<td>70.6%</td>
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</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>37</td>
<td>23</td>
<td>62.2%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Southampton General Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>65</td>
<td>59</td>
<td>90.8%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>18</td>
<td>14</td>
<td>77.8%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>58</td>
<td>42</td>
<td>72.4%</td>
<td>No</td>
</tr>
</tbody>
</table>
Royal South Hants Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>10</td>
<td>8</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Multidisciplinary working

Staff at different grades and skills worked well together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Outpatient teams worked together to plan and deliver care and treatment. Clinical staff we spoke with reported they had good working relationships with consultants. We were told if there were problems with consultants the nurse in charge of the department would step in to sort out any issues.

We saw both nurse-led and healthcare professional-led outpatient clinics across the outpatient areas. For example, the dermatology nurse-led clinics including iontophoresis (electrical stimulation) and Botox therapy for hyperhidrosis (excessive sweating).

Specialist nurses worked across the outpatient areas. For example, in the dermatology department there was a specialist skin cancer nurse who supported patients with their individual needs.

During the inspection we observed good multidisciplinary working across many of the outpatient departments. For example, in the orthopaedic department we saw orthopaedic consultants working closely with physiotherapy staff.

Some specialities had multidisciplinary (MDT) team meetings. For example, the orthopaedic department had MDT meetings attended by consultants, nurses and physiologists. We saw oncology staff and Macmillan nurses worked together to provide continuity of care to patients.

The new manager in the patient service centre had initialised meetings with leading staff in the specialities to help better manage outpatient clinics, improve patient waiting times and reduce
delays to follow ups. This was hoped to bring a more cohesive approach to the scheduling of outpatient appointments between the teams.

Seven-day services
Outpatient services were provided from 9am to 5pm Monday to Friday. Some specialties offered appointments with an earlier start and some clinics ran later in the evening but this was not standard practice across the outpatient departments.

Some specialities ran ad-hoc clinics on Saturdays to reduce waiting lists. The ophthalmology department had recently been running clinics on a Saturday to meet demand.

There was no formal plan for seven-day outpatient services. Out of hours and weekend clinics were organised on an ad hoc basis according to patient demand and consultant availability.

Health Promotion
Staff were proactive in supporting people to live healthier lives.

Doctors, nurses and health professionals promoted good health during consultations. Staff we spoke with told us that patients were made aware of health benefits from stopping smoking, reducing alcohol consumption and maintaining a healthy diet. One patient we spoke with told us that he had been informed of healthy living during their outpatient appointments.

We saw a range of health promoting leaflets and posters displayed in all but one of the outpatient departments we visited encouraging health promotion. This included leaflets on ‘time to quit smoking/ time to get moving/ take time out/call time on alcohol’ for patients with heart problems in the cardiovascular thoracic department and leaflets on respiratory conditions such as bronchiectasis, breathing pattern disorders, oxygen treatment in the respiratory department. In the chemotherapy department there was a poster board explaining about winter respiratory viruses including flu and how you could prevent catching them.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards
Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Clinical staff we spoke with had a good understanding of the consent procedure. They explained consent was gained verbally prior to procedures being performed and for more complex procedures a consent form would be necessary.

Staff and patients we spoke with told us consent was always obtained prior to treatment. We observed nurses, healthcare assistants and allied health professionals obtaining verbal consent throughout the outpatient departments.
Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from September 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 89.8% of staff in the outpatient department compared to the trust target of 85.0%.

The breakdown by site was as follows:

- Southampton General Hospital: 87.7%
- Royal South Hants Hospital: 100.0%
- Princess Anne Hospital: 95.7%
- Lymington New Forest Hospital: 100.0%

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

Conversations with staff indicated they had a good understanding of their responsibilities towards the mental capacity (MCA) act and deprivation of liberty safeguards (DoLs). Staff in the ophthalmology department explained times when a patient might require a mental capacity assessment before attending clinics. Most staff we spoke with had not been involved in the process of DoLs. However, staff in the cystic fibrosis department could give us examples when they had to apply for a temporary DoLs.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff throughout outpatient services put patients at the centre of what they did. During the inspection we saw pleasant interactions between staff and patients. Staff spoke with patients and relatives in a kindly manner, using supportive language.

During the inspection we saw staff introduced themselves and took time to interact in a considerate manner. We were told by patients that no matter how busy the outpatient clinics and the demands on the staff, staff always tried to find the time to chat with them.

Reception staff were attentive to the needs of patients and tried to maintained patient’s privacy and dignity. We observed receptionists speaking to patients in an attentive and polite manner in all outpatient areas we visited and we saw notices on the reception desk asking patients to respect others privacy whilst waiting to talk to the receptionist.

Staff understood the importance of chaperones. We saw posters in all outpatient departments we inspected offering chaperone services. We were told by staff in the ENT outpatient department, all clinic appointments were chaperoned by a nurse or a healthcare assistant due to potential invasive procedure taking place. Whilst inspecting the dermatology outpatient department we observed a consultant asking a nurse to support him with a consultation.
We saw many examples of compliments that outpatient departments had received from patients about the kindness and compassion displayed by staff. Cards and comments that staff had been given by patients and their relatives were displayed on notice boards throughout the outpatient departments.

We spoke to 22 patients and relatives across both the Royal South Hants hospital and Southampton General hospital during our inspection, many had used the service for a number of years. Patients and relatives were positive about their experiences of care. We heard that staff were kind and caring and that communication was clear, open and empathetic. Examples included:

- The staff are smiley, pleasant and explained the procedure
- Everyone is very caring
- The staff are happy and pleasant each visit
- The staff are excellent at taking blood, very pleasant and friendly
- The staff are friendly if a little busy due to lots of patients
- Staff very friendly and helpful

The trust gathered feedback through the NHS Friend and Family Test (FFT) survey. This is a tool that gives people that use the service the opportunity to highlight both good and poor patient experience. During our inspection we observed that FFT forms were available in the outpatient departments. Patients could either put completed forms in the box provided or complete the form online. Post inspection we requested FFT information from the outpatient departments.

**Friends and Family Test Results**

Below is the overview of FFT performance in the outpatient departments from January 2017 to December 2018.

<table>
<thead>
<tr>
<th></th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trust</strong></td>
<td>Pos</td>
<td>Neg</td>
<td>Pos</td>
<td>Neg</td>
</tr>
<tr>
<td></td>
<td>97%</td>
<td>1.3%</td>
<td>95.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>94.9%</td>
<td>2.5%</td>
<td>91%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Cardiovascular thoracic</td>
<td>99%</td>
<td>0%</td>
<td>93.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>98.4%</td>
<td>1.6%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedic</td>
<td>97.5%</td>
<td>1.1%</td>
<td>99.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>100%</td>
<td>0%</td>
<td>96%</td>
<td>0%</td>
</tr>
</tbody>
</table>

FFT information for specialist medicine was further split up as can be seen below:

<table>
<thead>
<tr>
<th></th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cystic Fibrosis OPD</strong></td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Dermatology Outpatients</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Medicine D Floor</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>0%</td>
</tr>
<tr>
<td>Ophthalmology Outpatients</td>
<td>100%</td>
<td>0%</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Optometry</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Orthoptics</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Pulmonary Function</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>100%</td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
The trust overall had received over 95% recommend rate in the outpatient FFT. The trust did not supply us with the FFT response rate.

Emotional support

Staff understood the need for emotional support.

The hospital had a chaplaincy team who were on call 24 hours a day, seven days a week, who could provide listening and emotional support if requested by patients. The hospital also had a number of places around the trust set aside for the purposes of worship or quiet space.

Patients had access to the Macmillan information and support centre at the Southampton General hospital. The centre offered an information library, complementary therapies, counselling and benefit advice from trained staff and volunteers.

We were told by staff throughout the outpatient departments that a room would be made available if bad news had to be broken to patients.

When talking to staff, it was clear how passionate they were about caring for their patients and how they put patients’ needs at the forefront of everything they did.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients told us they had received enough information before their appointment to prepare them for clinic.

The majority of patients and relatives we spoke with across the outpatient departments said they felt actively involved in decisions about their loved one’s care and treatment. And were given time to ask questions. Examples included:

- I was involved in decisions
- The consultant explained things in ways I could understand
- I felt part of the decision
- All my questions were answered

We observed nurses and healthcare assistants explaining to patients what was going to happen during their clinic appointment. They made sure patients understood and used language appropriate to the patient.

Is the service responsive?

<p>| | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Centre</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Victoria House</td>
<td>97%</td>
<td>1%</td>
<td>94%</td>
<td>3%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
</tbody>
</table>
Service delivery to meet the needs of local people

The trust planned and was working towards providing services that met the needs of local people.

Outpatient services and clinics were provided from different locations in the local area, Southampton General Hospital (SGH), Royal South Hants Hospital (RSH), the Princess Anne Hospital and peripheral clinics at Queen Alexandra Hospital, Lymington New Forest Hospital and at the Countess Mountbatten House. The majority of clinics were located at the Southampton General hospital but some medical specialities located at the SGH ran their clinics from the Royal South Hants Hospital.

The patient service centre was responsible for booking all new outpatient appointments and most follow up appointments. The centre was open Monday to Friday 8am - 8pm and Saturday mornings 8.30am – 12.30pm. The extended opening hours were to ensure that patients who did not have access to phones during the day had the ability to book appointments. The trust was now using the national e-referral service across all its outpatient services. This meant that patients and GPs could directly book services using the electronic choose and book system.

To help reduce patients not attending their clinic appointments patients received a telephone reminder seven days prior to their appointments and were asked to confirm they would be attending. This call was automated. Two days prior to the appointment patients would receive a text reminder. Patients had the opportunity to opt out of this service if they so wished by contacting the patient service centre.

Information supplied by the trust post inspection showed they was an 7.7% DNA rate across all outpatient services for the previous year.

Did not attend rate

From July 2017 to June 2018,
- the ‘did not attend’ rate for Lymington Hospital (Peripheral Clinic) was lower than the England average except for in August 2017 when the ‘did not attend' rate was higher than the England average.
- the ‘did not attend’ rate for Princess Anne Hospital was lower than the England average.
- the ‘did not attend’ rate for Queen Alexandra Hospital Peripheral Clinic was higher than the England average during July, August, September 2017, December and February 2018. Queen Alexandra Hospital Peripheral Clinic ‘did not attend’ rate was lower than the England average in October 2017 and May 2018. Queen Alexandra Hospital Peripheral Clinic was similar to the England average for the remaining five months.
- the ‘did not attend’ rate for Royal South Hants Hospital was lower than the England average.
- the ‘did not attend’ rate for Southampton General Hospital was lower than the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, University Hospital Southampton NHS Foundation Trust.
The outpatient service ran rapid access clinics. There were rapid access clinics that supported patients receiving care in a timely manner without being admitted to the emergency department such as the head and neck hot clinic which offered assessments and minor procedures for urgent patients. Other rapid access clinics ran daily Monday to Friday such as the nurse-led rapid access chest pain clinic and the rapid access vascular clinic.

**Meeting people’s individual needs**

The service took account of patient’s individual needs, they tried to plan and provide services in a way that met the needs of the people.

Most patients we spoke with where happy with the appointment letter they had been sent before attending the hospital.

The trust had good plans in place to contact and look after patients with no fixed abode who needed to attend outpatient clinics.

Patient transport services were available to those patients that met the eligibility criteria based on the department of health guidance. We saw notices throughout the outpatient departments reminding patients to inform staff if they were using patient transport services so staff could contact the transport services to get their returned transported booked and on the system. In the orthopaedic department patients arriving by transport were flagged and they were moved higher on the clinic list to make sure they did not require transport to take them home during rush hour, which let to patient transport delays. Staff in most outpatient departments reported problems with the transport service, for example we were told they would be kept waiting after the department had closed with patients waiting for transport to take them home as transport was often delayed.

Not all clinics had easy access or enough space to fit wheelchairs in. High-back chairs with arms to accommodate older patients or those with mobility issues were not available in most outpatient waiting areas. Bariatric chairs were seen in the majority of waiting areas.

(Source: Hospital Episode Statistics)
The majority of outpatient clinics had a receptionist where patients could book in when they arrived. Some clinics had a self-check in screen. We were told by staff working in the department that patients did not like using the screen with comments being they did not want to touch the screen due to the possible infection risks or found it difficult to operate the self-check in screen.

In many of the outpatient departments we saw signs telling hearing impaired patients there was a hearing loop. This is a special type of sound system for use by people with hearing aids. The hearing loop provides a magnetic, wireless signal that can be picked up by the patient's hearing aid when it is set to a certain setting. This can help reduced background noise and competing sounds that lessen clarity of sound in a public area.

There was a mixture of information presented to patients when entering the different outpatient departments, some clinics had photo boards of key members of staff, some had a list of which consultants were running clinics that day, some had information on clinical staff’s uniforms. However, there was no standardisation across all outpatient departments on what information should be on display to the patients.

Although translation services were accessible across the outpatient services there was no information displayed to let patients know this. However, information on the trust webpage did advertise that a translation service was available at the trust in English and five other languages. We were told by staff working in the outpatient departments that if an interpreter or sign language was needed by a patient in clinic, the patient services centre (PSC) could book an interpreter prior to the appointment. Although staff said they mainly used friends and family of patients to help translate if needed. This is not best practice as interpretation undertaken by people involved with the patient may be distorted (due to over protectiveness, bias, conflicting interests or lack of understanding of clinical terminology) and may not be an appropriate way of communicating confidential information. The trust ran a course for staff with an existing foreign language skill to become a trust-wide translator.

We observed a range of relevant patient information leaflets were available in the outpatient departments. Patients could access leaflets in large print, braille or on audiotape if needed. Leaflets were in English however we saw signs, in English, telling patients leaflets could be downloaded via organisational websites in another language if needed.

Patients with additional needs or requirements were flagged on the appointment system, meaning that staff could plan for their visit in clinic appropriately.

Staff we spoke with, understood the importance of chaperones and they explained they provided them on request or would offer their services. We saw posters in outpatient areas offering chaperone services. We were told by patients we spoke with that a chaperone had been offered to them.

We were told by staff in the ENT department they would put a green discreet dot on consulting room doors when a patient was receiving difficult news. This was to alert staff not to enter the room and to be mindful of the patient when they left the room. This demonstrated staff being responsive to the needs of the patient.

In the rheumatology department the team offered a non-emergency advice-line to patients. A specialist nurse would ring patients back within 24-48 hours. This service could receive up to 40
calls a day. The staff told us that this service received good feedback from patients.

**Access and flow**

**Most people could access the service when they needed it. Waiting times from referral to treatment were not in line with good practice for all of the outpatient specialities.**

The NHS constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All NHS acute hospitals are required to submit performance data to NHS England, who then publish a report on how hospitals perform against this standard. The maximum waiting time for non-emergency consultant-led treatments is 18 weeks from the day a patient’s appointment is booked through the NHS e-referral service or when the hospital or service receives the referral letter.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From September 2017 to August 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse the England overall performance. The latest figures for August 2018, showed 86.1% of this group of patients were treated within 18 weeks versus the England average of 88.4%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, University Hospital Southampton NHS Foundation Trust.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Seven specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).
Eleven 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>General medicine</td>
<td>98.7%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.6%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>96.1%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>95.9%</td>
<td>89.1%</td>
</tr>
<tr>
<td>General surgery</td>
<td>94.9%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>87.1%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>85.2%</td>
<td>83.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – incomplete pathways**

From September 2017 to August 2018 the trust’s referral to treatment time (RTT) for incomplete pathways has been similar to the England overall performance. The latest figures for August 2018, showed 86.9% of this group of patients were treated within 18 weeks versus the England average of 86.8%.

**Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, University Hospital Southampton NHS Foundation Trust.**
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Eight 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>Dermatology</td>
<td>96.4%</td>
<td>90.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>96.4%</td>
<td>89.7%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>93.9%</td>
<td>88.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>91.1%</td>
<td>84.3%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>90.3%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>90.0%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>86.7%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>86.2%</td>
<td>84.5%</td>
</tr>
</tbody>
</table>

Ten 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>General medicine</td>
<td>92.2%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>90.2%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Other</td>
<td>89.3%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>86.5%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>85.6%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>85.6%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>82.6%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>81.4%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>80.3%</td>
<td>85.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
There are different targets for patients with symptoms that could be due to cancer. In England, patients should wait no longer than two weeks from an urgent GP referral to seeing a specialist. In addition, there should be no more than 62 days waiting time from the date the hospital receives the urgent referral and the start of treatment and no more than 31 days waiting time from the meeting at which the patient and the doctor agree a treatment plan and the start of treatment.

**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust is performing worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust performance has declined in the latest quarter below the standard and England average. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), University Hospital Southampton NHS Foundation 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)**

The trust is performing worse than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). Performance has dropped below the national standard and England average in the latest three quarters. The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), University Hospital Southampton NHS Foundation Trust**

(Source: NHS England – Cancer Waits)
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. Performance has dropped below the national standard and England average in the latest two quarters. The performance over time is shown in the graph below.

Referral to treatment times (RTT) were usually monitored by the operational manager in the speciality care group rather than within the patient service centre. The newly appointed manager of the patient service centre (PSC) was beginning to work closer with the care groups to have a joined-up approach to maintain or reduce RTT times in outpatients. We were told by staff in the orthopaedic department that there had been times when clinics had capacity but patients had not been booked in by the patient service centre. However, by talking with the PSC team these issues had been resolved.

Most patients we spoke with told us availability of appointments was good.

The patient service centre had its own monthly targets to answer patient calls in 45 seconds. The month prior to the inspection the centre answered 90% of its calls within this time frame. However, the average waiting time overall was 59 seconds.

Information provided by the trust post inspection showed that in 2018 that 8.7% of outpatient clinics had been cancelled. 5.1% were cancelled six weeks or more prior to the appointment date.
and 3.6% were cancelled less than six weeks prior to the appointment date. Ophthalmology department at the Southampton General hospital and trauma & orthopaedics department at the Royal South Hants hospital were the outpatient departments with the highest cancellation rate of 13% and 10% respectively. The main reason for appointment cancellations were due to rescheduling of the patient (3%) or staff absent (5%).

Cancellations were monitored by the medical specialities in the care groups. The patient service centre had piloted a scheme where if they were informed of any cancellation in clinic they there could offer a short notice appointment. This meant a text message would be sent to patients who had indicated that they would be available for clinics at short notice. Patients who responded first would be allocated the cancelled appointment slot. This was a responsive way to make sure clinics ran full.

Clinical staff across the outpatient departments told us they would try very hard not to turn patients away and would fit them into clinic. This was responsive but could lead to delays for other patients waiting in the clinic.

We were told by staff that delays in appointment times would be announced to patients in waiting areas, either verbally or on electronic screens / whiteboards. Although we saw space for staff to show waiting times in the outpatient clinics we visited, most clinics we visited did not display waiting times or delays in waiting times. Many of the patients we spoke with during the inspection had been waiting over 30 minutes for their appointments.

The service did not routinely measure the number of patients who were not seen within 30 minutes of their appointment time. This meant the service was not collecting evidence-based information to know how many appointments ran late, to understand why appointments were running late and ultimately help improve the quality of outpatient services.

We were told that healthcare assistants in the rheumatology department had been trained to take blood. This meant patients did not have to go to the phlebotomy department to be seen and made their hospital visit shorter.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which was shared with staff. However, the trust did not always respond to complaints in a timely manner.

Summary of complaints

From September 2017 to August 2018 there were 87 complaints about outpatient services. The trust took an average of 55.0 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 35 working days.

- Southampton General Hospital: There were 74 complaints. The following subjects had three or more complaints:
  - Communication with patient; nine complaints
  - Appointment delay (including length of wait); eight complaints
• Appointment - failure to provide follow up; five complaints
• Attitude of medical staff; four complaints
• Post-treatment complications; three complaints
• Failure to act in a professional manner; three complaints
• Delay in treatment; three complaints
• Delay/ failure in treatment/ procedure; three complaints
• Lymington Hospital; one complaint due to delayed appointment.
• Princess Anne Hospital: five complaints:
  • Communication with patient; three complaints
  • Inappropriate treatment; one complaint
  • Breakdown in communications; one complaint
• Royal South Hants Hospital: seven complaints:
  • Post-treatment complications; two complaints
  • Delay/ failure to diagnose (including missed fracture); two complaints
  • Attitude of medical staff; one complaint
  • Delay/ failure in treatment/ procedure; one complaint
  • Inappropriate treatment; one complaint

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

Number of compliments made to the trust

From September 2017 to August 2018, there were no compliments within outpatients.

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

Staff in the outpatient departments told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. If the problem could not be resolved by the team, staff told us patients would be given contact details of the patient support service.

Information regarding the services the patient support service offered, including how to make a formal complaint and how to contact them, was displayed in prominent areas in the outpatient departments, in the form of posters and a ‘have you say’ leaflet. Information could also be found on the trust website, including a ‘have your say’ leaflet you could download. The service had a visible presence within the main entrance of the hospital with their offices open Monday to Friday 9am to 4pm.

Outpatient staff told us that feedback from complaints and concerns were discussed at the team meetings, during daily face to face catch ups and in handover sessions. Staff we spoke with could give us good examples of learning from complaints and concerns and genuinely viewed these as an opportunity for improvement. The staff in the rheumatology and managed care department escalated complaints about parking and this had let to disabled parking spaces outside the department.

In the rheumatology and managed care department at the Royal South Hants hospital we saw ‘you said, we did’ boards and the cardiovascular thoracic department had a poster informing
patients how they were improving from feedback and complaints from patients. However, there seemed to be no universal approach on how to display and feedback learning from patient complaints in the outpatient departments.

We reviewed minutes from monthly care group governance meetings and saw that complaints were discussed.

Is the service well-led?

Leadership

Managers in the trust had the right skills and abilities to run a service providing high-quality sustainable care. However, it was unsure if senior staff had full oversight of the outpatient departments.

The trust was split into four divisions: division A, division B, division C and division D. Each division had a management structure in place and clear lines of responsibility and accountability. The divisions were further split up into medical speciality care groups, with each care group having a care group clinical lead, care group manager and one or more matrons.

Outpatient departments were managed in the care group to which the medical speciality belonged and management was the same for all trust locations. The patient service centre sat in division C under the support services care group.

The majority of outpatient departments were managed on a day to day basis by a band 7 nurse with a team made up of band 2 to band 6 clinical and non-clinical staff. The band 7 nurse reported to the matron of the care group in which the outpatient department belonged to. The majority of matrons and care group managers where responsible for both the inpatient and outpatient areas in their speciality.

During the inspection we met and spoke with the band 7 leads in the outpatient departments. We found them to be enthusiastic, keen to improve their departments and supportive of their teams. In some of the teams, for example the ophthalmology department and the cardiovascular/oncology department, there had been recent changes in the band 7 role. The majority of staff we spoke with spoke highly of their band 7’s and this was especially true in the teams where the new band 7’s had been employed.

At clinic level throughout the outpatient departments we did not see matrons present. However, senior nursing staff told us they could contact their matrons when necessary and they found them to be supportive and approachable. However, we were unsure of the oversight matrons had for their outpatient departments. For example, when speaking to some matrons they could tell us in great detail about their responsibilities and how the inpatient services run but this was not the case when questioned about their outpatient departments.

There had been some new appointments in prominent positions in the outpatient departments and the patient service centre. It was too early days to see the impact these staff were having on the
services. However, staff working in the departments were already impressed with changes and the decisions being made.

We were told by staff working in some of the outpatient departments we inspected that outpatient departments had been side-lined in the past. However, staff could see changes beginning to happen with outpatients having more of a profile in the trust.

Outpatient staff at all levels spoke positively about the trust leadership team. We were told the chief executive and board members did walk rounds of departments. The ENT department at the Royal South Hants hospital had told us they had been over to their department to see them.

Vision and strategy

The trust had a vision for what it wanted to achieve and were working on plans to turn it into action.

The trust had a vision as summarised in their Forward document to ‘work with their partners at the edge of healthcare for the benefits of their patients’. How they planned to achieve this was detailed in their Operational plan 2017-19 which included the trusts approach to quality, activity, workforce and finance planning for the next two years. In addition, the trust had a patient safety strategy (2015 - 2018), a patient experience strategy (December 2012 – December 2016) and a quality governance strategy (2014 - 2017). All three strategies were needing review.

At an outpatient services level the operational plan included needing to reduce face to face outpatient follow-up appointments by 2020/21, reduce the DNA rate, to introduce new models of care outside of the hospital and to introduce a digital platform for patient booking and clinic management. The trust had a dedicated outpatient transformation steering group to develop a programme to reach these targets without compromising patient care and safety. Some progress had been made in the new to follow-up ratio, non-face to face appointments with patients being able to access their test results, upload clinical data and communicate securely with their clinical team through a digital platform. We were told by the trust a business case for accelerating the outpatient transformation programme was presented to the transformation board in November 2018 and the steering group were waiting to find out the outcome from this meeting.

We saw evidence of local adaptation of the outpatient transformation strategy whilst visiting the outpatient departments. For example, in the trauma and orthopaedics services the introduction of a virtual fracture clinic and virtual hip/knee clinic had seen a reduction in the patient wait time and DNA rates and in the rheumatology department had seen a reduction in follow up appointments by introducing a smartphone application that could manage early onset arthritis.

Although we were told about many of the new ways of working in the outpatient departments we inspected, staff did not tell us they were part of the outpatient transformation programme. Therefore, we were unclear how well the vision for outpatient services was being communicated down to staff working in the clinical areas.

Staff we spoke with were aware of the trust’s values of ‘putting patients first’, ‘working together’ and ‘always improving’. Staff told us these were the values they worked by each day.

Culture
Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The majority of staff we spoke with felt supported, respected and valued in their working environments and we could see this in practice when we inspected the outpatient departments. Staff described good teamwork amongst their colleagues and how they often felt their teams were like family.

Staff confirmed that they felt able to be open and transparent, reporting adverse events and incidents in a way which helped improve things within the service.

Across the outpatient departments staff told us they were proud of the service they provided to patients.

We were told by staff working in the outpatient departments that the culture had changed for the better. For example, consultant behaviour did not go unchallenged where it would have done in the past and bad behaviour was no longer tolerated.

As per NHS guidelines the trust had appointed a Freedom to Speak Up Guardian whom staff could talk to in confidence if they had concerns. Staff in the outpatient departments we spoke with were aware of the freedom to speak up guardian but had no experience of using the service.

**Governance**

There was no overarching governance structure for outpatient services. Outpatient services were managed under care groups specific to the clinical service.

Outpatient services were discussed at the monthly care group governance meeting for their medical speciality. For example, the chemotherapy department at Southampton General Hospital was discussed at the cancer care group governance meeting and the respiratory centre was discussed at the specialist medicine care group governance meeting.

Information from the care group governance meetings would feed up to the division governance groups. They in turn would feed up to the trust quality governance steering group (QGSG) which reported to the trust executive committee and ultimately the trust board. This showed a ward to board governance process.

We reviewed three months of minutes from the care group governance meetings and found that key quality issues of safety, risk, clinical effectiveness and patient experience was discussed. However, not all care groups had the outpatient department as a standard item on the agenda.

Meetings were consistent in their agendas in their divisions. For example, the ophthalmology care group used the same agenda as the specialist medicine care group, who were both in division B and the cardiovascular and thoracic care group used the same agenda as neurosciences care group who were both in division D. However, there was no standardisation between the divisions, division B and division D used different meeting agendas. This meant the trust could not be assured that divisions were covering the same topics in their governance meetings.
For some outpatient departments the matrons would prepare an exception report to take to the care group governance meeting. This included information on identified risks, non-compliance of performance against targets, complaints and action plan updates. We saw examples of exception reports from the ENT and surgical outpatient departments but staff were unsure if this report was used across all care groups in preparation for governance meetings.

We were told by staff in the outpatient departments that local staff meetings were held between the matron and the band 7 responsible for the day to day running departments and meetings outpatient team meetings. In these meetings information would be exchanged and concerns highlighted. Post inspection we requested minutes from these meetings but it seemed these meetings were more informal and were not minuted. Therefore, it was unclear how often these meetings took place and what information was shared within the team.

Some outpatient departments had introduced a morning huddle to update staff on the work plan for the day and any clinical or non-clinical issues. Staff told us they found these meetings useful and helped them keep up to date and plan for the day.

Senior staff in the outpatient departments told us they used different methods to disseminate information to their staff, with the use of emails, newsletters, lunchtime meetings and information displayed in staff rooms. During out inspection we saw this in practice.

Management of risk, issues and performance

The trust had systems for identifying risks, issues and performance and could cope with both the expected and unexpected.

The trust documented risk on different risk registers depending on the type of risk they were capturing. The trust’s corporate risk register captured overarching trust risks that would impact on the trust’s ability to deliver services. Outpatient services had one risk on the corporate risk register, the insufficient clinical and environmental capacity to meet rising demand for outpatients. Other risks relating to medical services were captured on the division’s risk registers. The four divisions had their own risk registers.

Individual outpatient departments did not hold local risk registers as risks requiring oversight were added to the division risk registers. Although risks were added to the division’s risk register we were told by the trust that risks were managed at the care group level.

Risk that reached a certain criteria or was thought to be of high enough risk would be placed on the corporate risk register.

It was unclear how outpatient services identified risk, although we were told post inspection that staff in the outpatient departments would fill out risk assessment forms if they suspected there was a risk in their local area of magnitude with help from senior staff. This would then be discussed at the care group governance meetings where it would be decided if it was a high enough risk to be added to the care group’s risk register.

When we reviewed minutes from the care group governance meetings we saw risks were discussed. Post inspection we requested the risk registers for the four divisions. From the
information we received we could see that risks were documented with information on when the risk was created, risk description, consequence description, current controls and any gaps in control. Risks were rated and actions agreed on how to migrate the risk and who had ownership of the risk. However, there was nowhere to record progress or date of last review of risk. It was unclear if we had been sent the whole risk registers or just examples of risks from the divisions. Therefore, it was difficult to know if all the risks we had been told about in the outpatient departments during the inspection were captured on the risk registers.

The care group managers were responsible for the collection and monitoring of performance indicators, such as referral to treatment time and cancer wait times, and would use this information to improve the quality of the service. We saw evidence from the minutes of the relevant governance and operational care group meetings that this data was discussed and used to improve outpatient services.

The patient service centre had started to implement meetings with each of the care group managers to discuss outpatient patient outcomes with the hope of working together to improve outcomes. It was too early to see if this combined approach was having an impact.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust used computer toolkits and dashboards to collect and monitor the outpatient services operational performance in national, commissioning and internal targets. Data on staffing, quality and safety was collected and reviewed.

The trust had started to implement an electronic document management system. This meant that patients records were available electronically and patient information could be captured electronically at the point of patient care. Most outpatient departments we inspected were paper light and moving towards electronic data capture. This meant all patient information was in the same place and easily accessible to staff, which improved patient safety and the patient experience.

The trust had a webpage where the public could access much information about the hospital, including information about the trust, patient services, patient and visitor’s information, how to make complaints and compliments and the latest hospital news.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The trust encouraged public engagement. They offered the friends and family test for the public to feed back their comments and help improve the outpatient services. They could do this on a paper form found in the outpatient departments or via the ‘patient and satisfaction’ tab on the trust’s website where patients could leave electronic feedback about their hospital experiences.
The trust had a website where the public could access much information about the trust and its hospitals including information about the outpatient clinics and services. There was information on the latest hospital news, charity news and when the trust had been in the media. The public could also find on the website details about how to get involved with clinical research, find details on support groups and the chief executive’s blog.

However, not all the information was kept up to date, for example the last chief executive’s blog was June 2018 and since then a new chief executive has come into post.

The trust also kept the public updated on twitter, Facebook and Instagram. Information on trust news, events and media stories were shared here.

The trust took part in the NHS staff survey and used the results to tackle and measure issues or themes raised by the staff. In the 2017 survey, the response rate of staff completing the survey was 45%. When benchmarked against other NHS trusts, the University hospital of Southampton was ranked as the best in the south for recommendation of a place to work and be treated. Areas of concern were issues with equality and diversity and violence and aggression. Whilst inspecting in the outpatient departments these were not issues raised by the staff we spoke with. We saw that the staff survey results were discussed at the care group meetings.

The trust provided information on their intranet pages and produced a newsletter and sent emails to keep staff updated on current and future plans and trust information. It was the individual’s responsibility to read the information supplied. Outpatient staff we spoke with didn’t always have access to computers to read emails regularly and said it was easy to miss newsletters but they did their best to keep up to date with trust news. They told us senior staff gave them information they needed to know to carry out their roles.

The trust ran the hospital heroes annual awards scheme to give recognition to staff and volunteers who had given exemplary service. These awards acknowledged individuals and teams who had made a significant contribution to the patient experience whether working directly with patients or behind the scenes supporting those delivering front line services.

Learning, continuous improvement and innovation
The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Many staff we spoke with from the outpatient departments had ideas of how they could improve the area they worked in.

We were told by staff working in the dermatology department the service had an ambition and a strategy not just to be the best service in the South of England but was striving for national and international recognition. The clinical lead was working with other providers, commissioners and educational institutions to ensure there was a local joined up strategy for future improvements and expansion. There were plans to develop eczema and psoriasis treatments with a developmental nurse specialist post and the department had developed micrographic surgery to establish the margins of basal cell cancers before excision ensuring complete removal at the first surgery.
We were told by the team working the rheumatology department that they had undertaken a project to improve the patient pathway which included facilitated discharge and the development of patient group directions (PGD) to be used in the department.

The trust was a major centre for teaching and research in association with the University of Southampton and other partners. Research studies and clinical trials are how we understand health better and develop new ways of treating or managing conditions. Whilst inspecting we saw many posters in the outpatient departments advertising for volunteers to take part in medical research programmes.
Acute services

Maternity (Princess Anne Hospital)

Facts and data about this service

Maternity Services at the Princess Anne Hospital is a tertiary provider of complex maternity and neonatal services including high risk maternal and I medicine and infants with complex medical and surgical needs. Births occurred in four locations: Labour Ward, the midwifery-led low risk birthing areas in the co-located Broadlands Birth Centre, stand-alone New Forest Birth Centre, and the home setting.

The maternity service included hospital and community settings ensuring that women received care across the antenatal, labour and postnatal periods. The service comprised of the pre–natal diagnostic service such as foetal medicine, ante-natal screening facilities and the Ultra Sound Sonography (USS) service.

Maternity services at Princess Anne Hospital provided unscheduled and emergency service alongside planned and responsive community acute care delivery. 75% of the service was delivered within a community setting, with approximately 51,000 antenatal contacts and 21,000 postnatal contacts.
The Trust has 80 maternity beds.

During the inspection we visited the Broadlands Birth Centre, a midwife-led unit which consisted of four birthing rooms, two of which were equipped with pools and four postnatal beds for women and babies.

Lyndhurst Ward (22 beds primarily used as antenatal beds, but often also housing post-natal women and babies).

Burley Ward (a 20-bedded postnatal ward).

The Labour Ward consisted of 14 birthing / delivery suites including a birthing pool.

The theatre suite which was adjacent to the delivery suite comprises of two obstetric operating theatres.

The midwives were organised into two teams delivering either midwifery or obstetric led care. This ensured that the workforce could respond flexibly to the demands of the service and maintain the skills of the midwifery staff working within each pathway.

Uncomplicated pregnancies were midwife-led throughout pregnancy and birth and the care of women with specific complications were managed by the midwives and the obstetric team using agreed pathways and guidelines.

Women were offered antenatal clinics with specialist midwives to support women with varied needs. The Trust had a day assessment unit where women requiring advice and treatment were triaged; staff were able to perform scans as outpatients, avoiding admissions and enabling women to return for checks if required.

The Trust told us that maternity services worked to ensure that the vision from Better Births was embedded into service development to ensure it was safe, well-led and met the needs of women.

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings.

During this inspection we spoke with 28 staff members across maternity services; including service leads, matrons, midwives, health support staff, midwives, domestics and administrative staff.

- We spoke with 12 women and their relatives and reviewed approximately 48 records across maternity wards including care plans, risk assessments, medicines charts and other records pertaining to the service.

(Source: Acute Provider Information Request – Context tab)
From January 2017 to December 2017 there were 5,352 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 babies delivered at University Hospital Southampton NHS Foundation Trust – Comparison with other Trusts in England.**

A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

### Profile of all deliveries (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivered (n)</td>
<td>Deliveries (%)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5,212</td>
<td>98.3%</td>
</tr>
<tr>
<td>Multiple</td>
<td>88</td>
<td>1.7%</td>
</tr>
<tr>
<td>Mother’s age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>144</td>
<td>2.7%</td>
</tr>
<tr>
<td>20-34</td>
<td>4,046</td>
<td>76.3%</td>
</tr>
<tr>
<td>35-39</td>
<td>889</td>
<td>16.8%</td>
</tr>
<tr>
<td>40+</td>
<td>221</td>
<td>4.2%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,300</td>
<td>596,828</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 (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivered (n)</td>
<td>Deliveries (%)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Gestation period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre-term 24-36 weeks</td>
<td>362</td>
<td>7.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.8%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>4,803</td>
<td>92.9%</td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

**Total number of deliveries with a valid gestation period recorded**

| Total                  | 5,171 | 498,704 |

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with **** (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the Trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at University Hospital Southampton NHS Foundation Trust by quarter.

**SOURCE: HES – Deliveries (January 2017 – December 2017)**

**Is the service safe?**

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

**Mandatory training completion rates**

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

**Trust level**

A breakdown of compliance for mandatory training courses from September 2017 to August 2018 at Trust level for qualified nursing staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</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>Hand Hygiene</td>
<td>291</td>
<td>292</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major Incident Planning</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>289</td>
<td>292</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>286</td>
<td>292</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>279</td>
<td>292</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>274</td>
<td>292</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>268</td>
<td>292</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>264</td>
<td>292</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In maternity the 85% target was met for each of the eight mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from September 2017 to August 2018 at Trust level for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</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>Adult Basic Life Support</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for each of the eight mandatory training modules for which medical staff were eligible.

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

Midwifery and medical staff were given protected time to complete training in skills specifically required for maternity.

- The Trust had in place a training programme and the staff were expected to complete the mandatory specific training. Staff also completed additional training as part of their practice and to meet the requirement of registration with the nursing and midwifery council (NMC). These included recognition of the deteriorating women, resuscitation of the new-born, obstetric skills, cardiotocograph (CTG) and drills of emergency scenarios and other sessions according to service needs identified from risk or incident themes. We requested the Trust target for attendance at the obstetric skills training, we did not receive this information, which meant unable to be assured that the compliance rate for training had been met.
- Staff told us 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).
- 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 was based in the hospital unit using hospital equipment so staff had local knowledge of how to deal with emergencies.
- Staff had completed K2 training which was a perinatal training programme in foetal monitoring.
Safeguarding

Staff were aware of processes and standard procedures to keep people safe from abuse. Staff received training to assess, recognise and report abuse.

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

Trust level

A breakdown of compliance for safeguarding training courses from September 2017 to August 2018 at Trust level for qualified nursing staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</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>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>276</td>
<td>289</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>31</td>
<td>37</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to August 2018 at Trust level for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</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 2)</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was not met for safeguarding training module for which medical staff were eligible.

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

- There were safeguarding policies and procedures which staff were confident in using to safeguard women and babies as required.
- Between December 2017 and December 2018, the Trust told us maternity services had 38 cases were input into the NHS Digital female genital mutilation (FGM) database. This is dataset supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England. The UK government is committed to preventing and ending female genital mutilation in the UK. There were 11 cases sent for information sharing with Children's Social care in accordance with the risk assessment and local/national guidance.
- The maternity service at the Trust had made 110 Multi Agency Safeguarding Hub (MASH) contacts across Hampshire and Southampton Children's Social Care.
- Maternity service had a specialist team of safeguarding midwives which included lead midwives for domestic violence, safeguarding, newly appointed female genital mutilation lead midwife, a peri-natal mental health midwife and a substance misuse lead midwife. Staff
told us that safeguarding was part of their daily practice and assessments of women were given high priorities.

- All staff we spoke to knew how to raise safeguarding issues or concerns. Staff said they completed an electronic incident form and informed the midwife in charge or the safeguarding specialist midwife team. All staff were aware of who the Trust’s safeguarding lead was and how to contact them.
- Staff were aware and how to report female genital mutilation (FGM) and spoke to us about safeguarding women and female children. 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.
- We saw other information was available at the Trust such as a checklist for first disclosure of FGM and action staff should take and including informing the police if a child was under 18 years of age.
- The Trust had procedures in place for all women and girls with acute or recent FGM require police and social services referral via the Maternity Safeguarding team. Two staff members we spoke with were aware of the actions they would take. A staff member told us they would contact the safeguarding midwife for advice.
- Safeguarding training in FGM was available to midwives and staff said was very useful as it included referrals processes.
- Safeguarding drop in sessions were held by the safeguarding team at regular intervals in the main hospital which midwives attended.
- The safeguarding team provided training to other staff, case supervision, helped and advised on risk assessments as needed.
- A representative from the safeguarding team was a member of the multi-agency safeguarding hub. They attended regular reviews were cases were discussed and cascaded information to the other midwives as part of learning from incidents.

Cleanliness, infection control and hygiene

The infection control measures to prevent the spread of infection was not consistently followed.

- The standard of cleanliness at Princess Anne Hospital was variable particularly in areas such as the birthing pool on the labour ward, Burley and Lyndhurst wards. The shower cubicles in Burley and Lyndhurst wards were in poor state of repair which impacted on staff’s ability to clean these areas effectively. Staff told us that the shower cubicles overflowed regularly posing infection control risks.
- On the labour ward, we found the birthing pool was not clean and the birthing balls were stained and needed to be replaced. There was no cleaning schedule for the birthing pool and staff could not provide evidence of when the pool was last cleaned.
- There were no guidelines for effective infection control of birthing pools when we asked the staff. There was no evidence that the outlet and taps were flushed in line with guidance as
staff told us they didn’t keep a log of flushing and cleaning of the pool on the labour ward. The Trust has confirmed there were guidelines in place although staff were unable to locate these guidelines at the time of the visit.

- The curtains in the obstetric day unit where women were admitted for induction were stained and we observed they were smeared with gels on the first day of our inspection. We checked the area again two days later and found the curtains had not been changed. We were not assured that infection control procedures were adhered to safeguard women and babies from the risks of cross infection.

- Other areas such as the Broadlands unit, labour ward and the New Forest Birthing Centre (NFBC) we visited were visibly clean tidy and uncluttered. There was a system to identify equipment that had been cleaned and ‘I am clean stickers’ were used. There was a room cleaning form in the birthing pool rooms in Broadlands and NFBC to identify that the birthing rooms were clean and ready to use.

- The staff observed bare below the elbows procedures when working in the clinical environment. Hand gels were available at the entrance to the unit although there was a lack of signage to advise visitors to use hand gels when accessing the unit and the wards.

- Midwives who worked in the community and attending home births were provided with hand sanitiser, personal protective wear required to ensure effective infection control procedures were adhered to.

- There were no MRSA or clostridium difficile cases reported in the maternity services. MRSA is a bacterium responsible for several difficult-to-treat infections and clostridium difficile is an infective bacterium that causes diarrhoea.

- In November 2017 the trust reported possible contamination of air supply in the surgical theatres. Three cases had been completed before this issue was identified and the operating theatre was shut down. Staff told us the fault with the air supply had been resolved. The Trust told us theatres were closed for a period whilst the estates team investigated and addressed the issues and the theatres were re-opened.

Environment and equipment

The environment and emergency equipment were not always maintained safely as all necessary checks were not completed.

- Emergency resuscitation equipment were not always managed safely. Staff did not consistently follow the Trust’s procedures and daily checks of the emergency equipment were not completed. This posed risks that equipment may not be available in an emergency and fit for purpose.

- We looked at the resuscitation trolleys on the Labour Ward and found the records of daily checks had not been completed for 15 days in November 2018. In October 2018 the daily checks had not been completed for 12 days. This posed serious safety risks and the Trust could not be assured that the emergency equipment was fit for purpose and available when needed in an emergency. We raised this with managers at the time of the inspection.

- The resuscitaire should have monthly filter changed in line with the Trust procedures; the records for October and November 2018 did not evidence this had been completed.

- There were two of the three women and visitor lifts in operation while one of them was being refurbished. This was first put on the maternity risk register in 2011. At the factual accuracy stage, the Trust told us the risk register entry related to the old lifts before the
refurbishment and reflected the unpredictable failures that occurred. Staff told us work would not be completed until April 2019. The Trust had recognised that failure of another lift would leave the maternity service with one lift and would have a high impact on care provision. At the factual accuracy stage, the Trust told us they had emergency procedures in place.

- At the time of the inspection, staff had also raised concerns that the lift no longer had the facility to be overridden in the event of an emergency. This posed risks to women and babies who needed to be transferred to the labour ward and operating theatres.
- Women were cared for in Broadlands unit which was on a floor above the labour ward. There was no dedicated patient lift and there was no facility for overriding the lift if needed in an emergency. Staff told us this facility for override was available previously and they had been asking for this to be looked into.
- Staff said they had raised their concerns with management about the lift facility for maternity services. This posed serious risks for the transfer of women in an emergency either to theatre or the labour ward. This could impact on women and babies in receiving timely care in an emergency.
- The shower rooms on Burley, Lyndhurst and Broadlands wards were not fit for purpose and staff told us these had not been updated and were well overdue. The cubicles were dark and staff told us the flooring was unsafe due to flooding from the shower cubicles. We noted this was on the maternity risk register and issues included that absence of costs allocated and definitive plan for interim measure and long-term refurbishment. A quality review was carried out in April 2016 which showed shower rooms were still not fit for purpose, although small remedial work had been carried out, however; this had not improved the shower rooms or reduced the risk of flooding. Senior staff member told us there were plans for the refurbishment in the next few months. At the factual accuracy stage, the Trust has told us the work was planned and would be completed in six to twelve months’ time. At the last inspection we highlighted the ageing environment and particularly the draughty windows which allowed water to seep in. Staff told us they were waiting for window replacement and some areas were cold. Following the inspection the Trust told us that work was planned to replace the windows in six to twelve months.
- The birthing pool room on the labour ward had a mobile heater as staff told us that was needed due to the room being very cold. Staff were unable to confirm if this heater had been risk assessed when we asked about it.
- There were security weaknesses in the Princess Anne building. There were four different entrances to the building. Staff confirmed there was no security presence on site.
- There was not always reception staff presence at the entrance to Burley and Lyndhurst wards as they also provided cover to other wards. This meant it was relatively easy to tailgate someone else to gain entry to the unit. We observed this during the inspection as we were preparing to leave the ward on three occasions.
- The double doors to both wards were open with no further security measures in place (such as a key pad lock). Staff raised their concerns about the weak security to both wards. They reported incidents of intimidation which occurred about a couple of times a month. There was no alarm system, no CCTV, no radio system to summon assistance and no barrier to prevent someone accessing the receptionists behind the desk.
- This risk was on the risk register and was scored at 15. Current controls were only for specific times during the night and weekend, gaps in control we were told was not effective. Staff told us they had raised the lack of security issues with the trust’s management and
they had to ring the main hospital site if they needed security support which they said may not arrive in time.

- The unit also cared for several vulnerable women including those suffering from domestic violence and trafficked women which posed added safety risks to these women and babies. Staff told us the unit did not use any electronic security tags for babies which may pose risks to babies being abducted or removed from the unit.
- We raised some security concerns across maternity services and at the main site with the senior management. Following the inspection, the Trust told us that they were developing a missing baby policy which was in draft, which meant currently there was no policy for staff to be working with. This may pose risks to the safety of women and babies.
- The provider has told us that themes of the week notices were used to raise awareness. We also received a copy of their missing baby policy following the inspection.
- The obstetric induction of labour area was not fit for purpose. There were four cubicles which offered a service in cramp conditions, with only curtains separating the beds, it was windowless with no air-conditioning. The unit accommodated and cared for high risk women and staff said it was difficult to meet service demands. There were serious issues with maintaining confidentiality, privacy and dignity.
- There was appropriate equipment on the emergency trolley, including infusion sets and items for dealing with massive obstetric haemorrhage and anaphylactic events. Anaphylaxis is a severe allergic reaction that can be life threatening. The staff had access to the neonatal resuscitation trolleys which were well maintained and all checks were completed as required by the neonatal team and was in line with the Trust policy and procedures.
- The Broadlands centre was also well maintained including the birthing pool room. However; the two birthing rooms and the birthing pool room did not have any heating which staff said impacted on women receiving care.
- The Labour Ward had a variety of equipment including resuscitaire to meet the needs of women and babies. However; the birthing pool room was cold and draughty and in poor state of repair which included large gaps in the ceiling tiles.

Assessing and responding to patient risk

- Staff used an overarching risk assessment tool for all families. This had been agreed across many agencies and was published by the multi-agency safeguarding children’s board.
- Areas of risk factors included, all young women under 16, any women known to adult or child safeguarding, any women with alcohol or substance misuse issues, any looked after child or care leaver.
- Other groups included homeless women, asylum seekers, illegal immigrants, refugees, any trafficked women, those at risk of exploitation (including sexual), women with a learning disability, and those women with mental health issues.
- Women experiencing domestic abuse, and those women having undergone female genital mutilation (FGM) were referred to the specialist midwives team for advice and support.
- We saw antenatal risk assessments and screening for safeguarding and mental health had been completed.

Midwifery and nurse staffing
• The Trust had two consultant midwives in post. These were qualified midwives who had received further development through academic and practical clinical experience enhancing their midwifery skills to become experts in midwifery practice and leadership. The Consultant midwives were responsible for providing clinical support to midwives and women along the midwifery led pathway. They contributed to the governance of the service as leads for audit and clinical effectiveness. The trust told us they offered supervision and support to midwives and played an active role as advisors to the senior programme and hosted the trainees within the four-year programme.

• The Trust’s needing extra support team (NEST) worked within community areas and offered a ‘named midwife’ for a case load of women. The NEST midwives provided antenatal, intrapartum and postnatal care in the unit, birth centres or in the community.

• The Case-loading teams organised their working hours within their teams. They provided 24 hour on-call cover for their teams’ caseload, if they were unable to support due to sickness, the women were cared for by staff in the maternity unit.

• The Theatre workforce has a dedicated team of nursing/operating department practitioners (ODPs) and healthcare assistants employed to assist in elective and emergency obstetric lists.

• Those families with socially complex needs fell within the needing extra support team (NEST) remit and this increased demands on midwifery time, in relation to safeguarding and child protection. Staffing was planned in recognition of this and this team had fewer women on their case load midwifery than that of a midwife with a universal caseload.

• Staff told us that the NEST team was invaluable in providing support to women and staff. However there had been some challenges with sickness and recruitment to the NEST team. The Trust had put in a plan to address this by offering all women who were planning a home birth to be cared for by the NEST team. This would increase the diversity of women cared for by the NEST team and widen the interest group of midwives who were eligible to apply for these posts. The Trust has also purchased external clinical supervision to this group of midwives, to enable them to reflect and receive support in their roles.

• The Trust had recruited 43 new midwives in the preceding 18 months. Staff told us that mostly they felt there were enough staff to deliver care safely and effectively.

Planned vs actual

The trust has reported their staffing numbers below for August 2018.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Scheduled</th>
<th>WTE in post</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princess Anne Hospital</td>
<td>251.31</td>
<td>257.10</td>
<td>102%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From September 2017 to August 2018, the Trust reported a vacancy rate of -7.3% in maternity. This was lower than the Trust target of 12%. The negative figure indicated that there were more midwives in role than had originally been scheduled.

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

Turnover rates
From September 2017 to August 2018, the Trust reported a turnover rate of 11.1% in maternity. This was lower than the trust’s rolling 12 months target of 12%.

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

Sickness rates

From September 2017 to August 2018, the Trust reported a sickness rate of 4.2% in maternity. This is higher than the Trusts rolling 12 months target of 3.5%.

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

Bank and agency staff usage

From September 2018 to August 2018, the Trust reported that 3.5% of qualified nursing shifts in maternity care were filled by bank staff and 0.0% of shifts were filled by agency staff.

(Source: Routine Provider Information Request (RPIR) – Nursing bank agency)

Midwife to birth ratio

From April 2017 to March 2018 the Trust had a ratio of one midwife to every 22.89 births. This was lower than the England average of one midwife to every 25.68 births.

(Source: Electronic Staff Records – EST Data Warehouse)

- The Trust reported in 2017 there were 5626 births at across the maternity services which was slightly down from 5749 in 2016.
- The midwife to birth ratio at this Trust has improved since the last inspection which was at 1:31.
- The Trust told us that assessing the midwife to birth ratio depended on the demographic, acuity of women and combination of midwife led and obstetric services. The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) states there should be an average midwife to birth ratio of 1:28.
- At this Trust the midwifery staffing has been funded at levels of a 1:26 midwife to birth ratio but not to 1:24 midwife to women ratio for a service with a high risk and complex population of women in line with recent Birthrate Plus workforce report. (Source: Trust board papers April 2018).

Medical staffing

Planned vs actual

The Trust has reported their staffing numbers below for August 2018.
Vacancy rates

From September 2017 to August 2018, the Trust reported a vacancy rate of -0.5% in maternity. This was lower than the Trust target of 12%. The negative figure indicated that there were more staff in role than had originally been scheduled.

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

Turnover rates

From September 2017 to August 2018, the Trust reported a turnover rate of 0% in maternity. This was lower than the trust’s 12 months rolling target of 12%.

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

Sickness rates

From September 2017 to August 2018, the Trust reported a sickness rate of 0.3% in maternity. This was lower than the trust’s 12 months rolling target of 3.4%.

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

Bank and locum staff usage

From September 2017 to August 2018, the Trust reported no bank and locum usage in maternity.

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

Staffing skill mix

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

Staffing skill mix for the 50.5 whole time equivalent staff working in maternity at University Hospital Southampton NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Scheduled</th>
<th>WTE in post</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princess Anne Hospital</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
^ 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)

Never Events

From August 2017 to July 2018, the Trust reported no incidents which were classified as never events for maternity.

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))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the Trust reported four serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2017 to July 2018.

The breakdown of the types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with 2 (50% of total incidents).
- Pressure ulcer meeting SI criteria with 1 (25% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with 1 (25% of total incidents).
Records

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

- There was a mixture of paper and electronic (E) records in use at the Trust. Senior managers told us the aim was introduce E records although they said this was work in progress.

- In the labour wards, records were maintained electronically which included partogram (graphical record of key data (maternal and fetal) recorded on a single sheet during labour) and Cardiotocography (CTG) which recorded the fetal heartbeat and uterine contractions during labour.

- We looked at 19 care records and each stage of the maternity pathway had an agreed proforma completed which included a prenatal module, a labour module, a theatre module and a postnatal module.

- Although some women’s records were fully completed, there were some inconsistencies in assessments such as venous thromboembolism (VTEs) were not completed in three out of five records.

- The maternity risk register updated in September 2018 had identified women observations at a critical stage in labour; aspects of basic care and key observations were not being recorded in line with guidance. The trust had developed an action plan which included holding a second stage of labour workshop and re audit in six months.

- We also reviewed three records of women who were admitted to the high dependency unit. The records included intra operative and post -operative notes were detailed with clear actions of clinical events. We observed women’s records were kept safely and securely.

- Women received the personal health record the ‘red book’ to keep details of their baby’s development and took with them to all future baby appointments and reviews.

- Records showed staff had completed a comprehensive assessment including, where appropriate, physical health, mental health and any social needs of women.
• Care plans reflected the individual woman’s needs that staff had identified during the initial assessment. Care plans were personalised, holistic and recovery focused, risk assessments and results were documented.

• Staff raised some concerns about the current process of scanned records as once scanned these were destroyed. We were told that the quality of the scanned records was sometimes in the wrong order making risk assessments and investigations a longer process, and risks of vital information being missed.

• Staff were concerned that during ward rounds and reviews, although the portals could be updated by the bedsides, any discussions outside of patient’s room cannot be documented directly on to the portal.

• The current process did not allow for women E records to be seen by other departments. When referrals and second opinions were sought, these were documented on paper although all other women and babies’ notes would be electronic at that point.

• On discharge home, an electronic summary was sent to the GP, the Health Visitor and the records were scanned into the Trust record system.

• Women continue to have a hand held maternity record as midwives were unable to easily access results and e-documents when working in the community. A senior manager told us that the Trust was working towards E-record in 2019, this was being progressed through the Southampton, Hampshire, Isle of Wight, Portsmouth (SHIP) Local Maternity System programme.

Medicines

The service followed best practice when prescribing, giving and documenting medicines.

• At the Princess Anne Hospital, following the last inspection we found the rooms where medicines were stored had keypad locked doors. Some emergency medicines were stored in unlocked medicine refrigerators; in these departments risk assessments were in place.

• In the induction of labour ward, we found medicines used for the induction of labour were not maintained safely and in line with manufacturer’s recommendation. The temperature of the fridge/freezer was not checked daily, the records were not completed on 7, 11, 13-16 and 27 November. For the previous month there were gaps on 8, 9, 10, 17, 18 and 31 of October. This posed risks, as the efficacy of medicines may be affected as this was not managed in line with manufacturer’s guidelines.

• Midwives administered and supplied medicines against Patient Group Directions (PGDs) and in line with maternity exemption (ME) protocols. Patient Group Directions (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 midwife prescriber). Supplying and/or administering medicines under PGDs should be reserved for situations in which this offers an advantage for women care, without compromising their safety.

• The trust had supported staff and provided training and were authorised to work to PGDs and ME. The Trust had a process to ensure PGDs and ME protocols were reviewed regularly.

• The department 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 we did not see any expired drugs in any department. This meant that there were regular drugs reconciliation to ensure women and babies received their medicines safely.
• The maternity services were gradually introducing self-administration of medicines. The patients’ bays and rooms had lockable cabinets for the safe storage of patients’ medicines. Policy updated in 2018.
• The service had medical gases which were stored in a room off the main corridor. There was no signage in the area where the medical gases were kept in line with the Trust procedures. This may pose safety risks as this area may not be identified in an emergency. We noted that full and empty cylinders were also not kept separately to minimise the risks of errors.
• The midwives collected the medical gas (gas and air for pain relief) cylinders from the unit when attending a home birth. The medication required for the birth of the placenta was collected from the fridge on the unit.

Incidents
• There were 1867 incidents reported during 2017, of which 35 were rated moderate or above and were subject to duty of candour disclosure. 18 serious incidents were reported and subject to a Root Cause Analysis (RCA).
• There was a process for reporting incidents which staff said they felt confident to use and followed their escalation procedures as required. Staff knew how to recognise and report incidents and used the Trust electronic recording system.
• 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 and this could only be completed by coming into the hospital to record.
• Incidents and lessons learnt from incidents were shared at the staff daily handover meetings, regular team meetings and at the monthly risk meetings where all incidents, themes, actions and the risk register were looked at.
• Between March 2017 and December 2018 there were five serious untoward incidents. The main themes of lessons learnt included: midwife skills and observations, handovers, risk assessing and escalation, staffing and culture.
• This was followed up and included a documentation audit day, labour workshop, midwifery back to basics education, breech birth workshops and cascade training, communication improvements, debrief and trauma risk management training.
• Following a root cause analysis related to discharge of a woman, the Trust had introduced triage midwives which allowed for direct referral from women and GPs into the Maternity service. This enabled the service to have an early contact with the women to highlight any actions or referrals needed.
• To assist learning, a “theme of the week” one sheet poster was sent to all staff. For example, we saw one briefing which advertised the emergency calls and cardiac arrest call procedures.
• As part of lessons learnt, the obstetric referral guideline had been recently updated which provided guidance for all staff involved in the referral, administration and management of women requiring antenatal obstetric referral.
• Staff were informed via their internal system such as “MQuest messenger” on a monthly basis, inviting them to a lesson learnt session. For example, in October 2018 staff attended a session looking at a clinical case of a woman who had experienced a placental abruption.
- The Trust told us they worked collaboratively with the Healthcare Safety Investigation Branch (HSIB) to ensure learning from safety incidents were shared widely.
- There was monthly communication sent out to teams called “be on the look-out”, for example, examining case studies looking at the importance of accurate risk assessing.
- Staff understood their responsibilities in relation to the Duty of Candour and told us they were open and transparent with women 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 women (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Safety thermometer

- The maternity safety thermometer is a measurement tool for improvement that focuses on incidents such as post-partum haemorrhage (excessive bleeding during/after labour), infection, separation from baby, perineal and abdominal trauma, incident of urinary catheters or urinary infections. Any falls and venous thrombo-embolism (VTE) blood clots.
- This allowed the team to take a temperature check on harms associated with maternity care but also reflected the proportion of mothers and babies who had received “harm free” care.
- During the inspection, we did not see any safety thermometer information displayed in the areas that we visited. Information was not available for women and visitors.
- At the factual accuracy stage, the Trust told us the maternity service was working with partners across the Local Maternity System (LMS) in development of a public Maternity Dashboard which was being tested and would be available to the women.
- The trust informed us that all cases of Perineal trauma (3rd and 4th degree tears) were reported via the internal Incident reporting systems.
- The data we looked at during the inspection the statutory safety thermometer returns were monitored and included VTE assessments was currently at 83.5%.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- We observed that the care and treatment was managed in accordance with national guidance. For example, 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.
- The Trust had developed guidelines in line with the World Health Organisation (WHO 2013) to support staff in recognising the types of female genital mutilation (FGM). The aim was to support staff in providing safe care and identify women at risk at an early stage.
- 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.
- Babies born with tongue tie were seen in midwife-led clinics. Several midwives had been trained to treat tongue tie in babies.
- Care was tailored to the women’s holistic needs, this was evident from feedback we received from several midwives. Fetal 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.
- Midwives monitored fetal growth using the fundal height measurement (from the top of the mother’s uterus to the top of the mother’s pubic bone), and plotted this using customised growth charts.
- The maternity service also carried out detailed ultrasound in the first and second trimester of pregnancy. They 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.
- Fetal 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 were assessed for jaundice and treated in line with NICE guideline QS57. A new mother told us about the diagnosis and treatment of their baby who had been diagnosed as having jaundice.
- Staff were aware of the latest sepsis guidelines and information included a detailed maternity sepsis screening and action tool in line with NICE guidelines.
- There was a process for senior managers to check that guidance was followed and staff provided care in line with guidelines.

**Nutrition and hydration**

**Women were supported to maintain a healthy diet.**

- Women were provided with advice on healthy eating and keeping hydrated during labour. The women we spoke with were complimentary about the food and fluid they received.
- Staff told us they provided infant feeding support for women in the community if they needed it. There were also baby cafes where women could attend for peer support and further advise.
- 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.
- The performance dashboard reported 74% of women initiated breastfeeding during quarter 3 and 77% in quarter 4. This was in line with the England average (Source NHS England
Artificial feeds were available to women wishing to bottle feed their babies. 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 maternity services were not accredited with UNICEF baby friendly initiative. They told us they had chosen not to apply for accreditation while it was not mandated.

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 women pain and provided information on different types of pain control available to them.

- Women received information about the type of pain control which would be available to them depending on where they chose to have their babies. Women Princess Anne Hospital choosing home births were offered gas and air. They would be transferred to if they required Stronger pain relief and epidurals. They would also have to provide their own birthing pool if they wanted to use this for home birth.
- Women we spoke with said they had received 'very good information’ and were supported to manage their pain and pain control of their choice was available. They said the type of pain control was discussed during the antenatal stage and they knew they could opt for stronger pain control if they needed.
- Birthing pools were available at the Broadlands centre, labour wards and included other equipment such as bean bags and birthing balls to support women during labour.
- Women we spoke with and midwives said pain relief was discussed at ante natal appointments and pain control choices and flexibility for women to change their minds.
- Information was available for women who chose to use alternative pain relief therapy. For example, transcutaneous electrical nerve stimulation (TENS) machines they would need to provide their own.
- The maternity service did not provide any complementary therapies for pain relief.
- Women could also have patient control analgesia (PCA) if needed which was available at the Princess Anne. PCA is a process where the pain relief is delivered via a pump and women could manage their own pain.
- Women could have epidural pain relief on the labour ward. This option was not available in the midwife led units and information about this was provided to women when they chose their place of birth.

**Patient outcomes**

- The Trust reported 75% of the service was delivered within a community setting such as maternity hubs in Hedge End, Royal South Hants. and the New Forest Birth Centre. This included 51,000 antenatal contacts and 21,000 postnatal contacts delivered in the community.
• The Maternity Services had developed the needing extra support team (NEST) that aimed to provide continuity of the midwife providing care to the woman, throughout the antenatal, intrapartum and postnatal period. Continuity of care was associated with 16% less likely to lose their baby, 24% less likely to have a preterm birth, 15% less likely to have an epidural and 16% less likely to have an episiotomy. (Source: Trust board paper April 2018).
• The maternity service contributed to the Better birth project, the Trust had developed community hubs across Southampton and Hampshire, 98% of women were seen in a community hub.
• The performance dashboard for 2016/2017 showed year to date figures for place of birth: 78% of all births occurred in the obstetric-led delivery suite, 13% in the Broadlands Birth Centre, 5% in the New Forest Birth Centre, 2% were planned home births, and 1% of babies were born before the woman arrived at the hospital.
• Midwives followed a pathway developed for women with raised BMI over 30 which included weight measurements at booking, 16, 28 and 36 weeks, ultra sound scans and dietary advice.

**National Neonatal Audit Programme**

In the 2017 National Neonatal Audit, Princess Anne Hospital performance in the two measures relevant to maternity services was as follows:

• Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 160 eligible cases identified for inclusion, 89.8% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit’s recommended standard of 85% for this measure.

• Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 58 eligible cases identified for inclusion, 56.9% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5%, and put the hospital in the top 25% of other units.

(Source: [National Neonatal Audit Programme](https://www.rcpch.ac.uk), Royal College of Physicians and Child Health)

**Standardised Caesarean section rates and modes of delivery**

From April 2017 to March 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>Type of caesarean</th>
<th>England</th>
<th>UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>540</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>850</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>1,390</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018

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.

In relation to other modes of delivery from April 2017 to March 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,390</td>
<td>26.2%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>754</td>
<td>14.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,156</td>
<td>59.5%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,300</td>
<td>100%</td>
</tr>
</tbody>
</table>

(n=596,828)

Source: Hospital Episode Statistics, April 2017 to March 2018

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

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of September 2018, the Trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The Trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 7.33.

This is up to 10% higher than the average for the comparator group rate of 6.71.

(Source: MBRRACE UK)

- We looked at the data on Insight did not support an improvement to safety with no measures showing an improvement and a deterioration in the stabilised and risk-adjusted extended perinatal mortality rate (MBRACE). The Trust was now worse than the national average for this measure.
- Trusts are required to participate and report on all National Clinical Audit and Patient Outcomes Programme projects as part of their NHS Standard contract. All NHS maternity units in England, Scotland and Wales are therefore expected to participate in the National Maternity and Perinatal Audit (NMPA).
- The Trust was identified as a potential outlier for the proportion of singleton, term, liveborn infants with a 5-minute Appearance, Pulse, Grimace, Activity, and Respiration (APGAR) score of less than 7. The APGAR score is a test given to newborn soon after birth. This test checks a baby’s heart rate, muscle tone, and other signs to see if extra medical care or emergency care is needed. The APGAR score is used to summarise the condition of a newborn baby, typically at 1, 5 and 10 minutes of age. A 5- minute APGAR score of less than 7 has been associated with an increased risk of problems for the baby.
- The Trust was required to undertake a review of the APGAR. The Trust told us they identified some discrepancy in APGAR score allocation and data inputting into the Hospital Integrated Clinical Support System (HICSS). This led to an in-depth audit of the women and babies’ records.
- They carried out an audit of 93 healthcare records to establish whether the APGAR recorded on the hand- written records matched the electronic records. The findings of the audit showed that 6 of the 93 records were incorrect (the written APGAR did not match the electronic record). With the data corrections made the site result changes from 2.3% to 2.1% (Improvement against the National mean of 1.2%). The maternity service had put in place recommendations to prevent this occurring in the future.
- All incidents of post -partum haemorrhage was reported using their internal reporting system.
- The maternity service lower number of total caesarean section at 26% compared to England’s average of 28%. They had higher instrumental deliveries such as use of forceps and Ventouse (suction cup used to deliver a baby) at 14% compared to England’s average of 12%.
- The maternity service had a guideline for sepsis in pregnancy which was revised in April 2018. There was no data currently regarding compliance with sepsis. The Trust told us an audit was planned to start in January 2019 to review antibiotic administration at planned and emergency caesarean births.
- The maternity service used the National Perinatal Mortality Review Tool in the review of stillbirths and worked with other providers to improve care for women and share learning.
Competent staff

Appraisal rates

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisal s required</th>
<th>Appraisal s complete</th>
<th>% completio n</th>
<th>Met target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified midwives)</td>
<td>268</td>
<td>228</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>130</td>
<td>95</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>7</td>
<td>5</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>7</td>
<td>5</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>50</td>
<td>35</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>17</td>
<td>11</td>
<td>65%</td>
<td>No</td>
</tr>
</tbody>
</table>

At the last inspection we had identified that the Trust was not meeting their staff’s appraisal rate. This had not improved at the time of this inspection. The Trust mandate was for each staff member’s annual appraisal was to include a well-being discussion, which helps them to identify any issues at work, or with work life balance, and discuss what support they could provide.

- From September 2017 to August 2018, only 79% of staff within maternity care at the Trust received an appraisal compared to a Trust target of 92%.
- Staff told us they valued supervision and appraisal of their practices; however not all staff were supported through this process. Senior managers told us they were aware that they were not compliant with this. Opportunities for staff to discuss well-being, work related issues were missed.
- Following the inspection, the Trust told us they had taken steps to improve appraisal rates, such as allocating protected times on the duty roster for staff’s appraisals.
- Midwives told us they had not completed supplementary training for managing the care of women choosing waterbirths. We were told they learned from experience. Staff said band 7 midwives had completed training, however; there were no records kept. This may pose risks to women and babies and inconsistent care.
- A preceptorship programme was available for newly qualified midwives supporting them to gain essential skills and competencies that allowed further development for their roles.
- Staff told us they also attended a home birth study day to ensure midwives felt confident and had the skills that they needed to facilitate birth at home.
- Midwives completed additional training including, human trafficking and asylum seekers, assessing risk, perinatal mental health, domestic violence and female genital mutilation (FGM) identification and referral processes.
- Midwives and obstetricians completed multi professional training such as the Practical Obstetric Multi-Professional Training (PROMPT)) which were skills drills training in obstetric emergencies. This is an evidence based training package for responding to
obstetric emergencies. This has been associated with improved clinical outcomes and reduced women’s safety incidents.

- The Trust held PROMPT training sessions each lasting an average of 40 minutes. This included shoulder dystocia and post-partum haemorrhage, transfers with cord prolapse/breech from the community and emergency delivery, maternal collapse, sepsis and anaphylaxis, cartograph and neonatal resuscitation. The aim of this added training was to ensure staff were kept updated with emergency procedures and could respond to women’s needs effectively and safely.

- PROMPT data compliance for the last 12 months showed a compliance rate between 90% and 100% for consultant obstetricians, anaesthetists, midwives and maternity support workers. Obstetric trainees including new intake was 51% and trainees excluding new intakes was 88%.

- Midwives at Princess Anne Hospital had achieved 92% for PROMPT training and midwife support workers had met the Trust’s target of 90%.

- Users received support through the process of revalidation with their professional body the nursing and midwifery council (NMC).

- The Trust told us they had an ‘in-house’ development programme for Band 6 nurses.

- The Safer Childbirth guidance recommends that consultants midwives are represented in the workforce at a ratio of 1:500 births. In Southampton there were two Consultant midwives with portfolios of normalising birth, public health, education and research. Southampton has led and participated in the South-Central Consultant Midwifery Trainee programme and development of this role.

**Multidisciplinary working**

- The maternity unit had a well-developed internal multidisciplinary team which included, nursing, medical team, health care support staff, theatre staff, physiotherapist, tissue viability specialists, neonatal team, anaesthetics and community midwives.

- Staff on the wards told us about the “excellent NEST team”. external multidisciplinary working with the NEST teams.

- The triage midwives referred women to the NEST team and there was effective working between all the teams.

- Women records showed staff followed their process and involvement of perinatal mental health midwife, GP and social worker as appropriate to meet women’s needs.

- The records for a woman showed plans were shared with labour line and local maternity units in case the woman presented elsewhere. After birth discharge plans were put in place. Midwife followed up for 15 days and successful handover to health visitor was completed.

- There was evidence of effective communication with GP’s during antenatal care/discharge, particularly case studies looked at from the NEST teams.

- Transitional care of babies from neonatal care to postnatal care and involvement of neonatal intensive care unit (NICU) and outreach/support were effectively managed.

- The Trust had consultant midwives were available to support women in their choices for their birth experience and to support midwives to deliver this care.

**Seven-day services**

- The maternity unit at Princess Anne and was accessible 24 hours a day, seven days a week. There were two birth centres which also provided 2h hour care. Midwives in the
community undertook home visits seven days a week and provided a seven-day, 24-hour home birth service.

- Women had access to seven-day service and consultant directed care for diagnostic investigations including CT, ultrasound as required.

Health promotion

- Midwives undertook a detailed assessment of women at the initial antenatal booking visit and supported women throughout the pregnancy as identified. Weight management including high body mass index (BMI), smoking cessation advice, breastfeeding advice were included.
- Healthy eating and weight management advice was also provided for women both before, during and after pregnancy.
- Influenza and whooping cough vaccines were offered to all pregnant women after 20 weeks gestation and information was available and displayed in the unit.
- Women were offered screening for sexually transmitted diseases at the initial assessment during antenatal appointments. Any positive results were managed by the ante-natal screening midwives for support and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff obtained and described consent to care and treatment in line with legislation.

- Staff understood their roles and responsibilities under the Children’s Act 1989, the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- We observed staff gaining verbal consent prior to providing care. Verbal consent was also gained prior to examinations, this was evident in records that we reviewed.
- The midwives we spoke with understood their responsibilities relating to Fraser guidelines and Gillick competencies when caring for a female under the age of 16. The Fraser guidelines refer specifically to consent for sexual health services, and are an additional guideline to the Gillick competency framework that relates to consent for any healthcare intervention.
- Staff told us that issues with capacity was uncommon, however midwives use the Trust guidance and protocols relating to capacity assessment and best interest assessments.

Mental Capacity Act and Deprivation of Liberty training completion

The Trust reported that from September 2017 to August 2018 Mental Capacity Act (MCA) training was completed by 85% of staff in maternity care, achieving the Trust target of 85%.

There was no separate module for deprivation of liberty.

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

Is the service caring?
Compassionate care

Staff treated women with kindness during all interactions we observed.

- Staff were kind and considerate when caring for women. We observed staff providing support to women when caring for their babies in a caring and compassionate way.
- We received positive feedback from women and their partners about their experiences of care they had received in the unit.
- We observed time took time to interact with women in their care and those close to them. Staff showed compassion when a woman was brought in after giving birth at home and was keen that the woman was supported as soon as they arrived and provided with assurance about their baby.
- Women who had opted for home births received help and support if they needed to be transferred to the main hospital.
- Staff were confident they could and would raise any concerns about inappropriate or disrespectful behaviour towards women and their families.

Friends and Family test performance

Friends and family test performance (antenatal), University Hospital Southampton NHS Foundation Trust

From May 2017 to May 2018 the Trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

In the most recent month, May 2018, performance for antenatal was 96% compared to the England average of 95%.

Friends and family test performance (birth), University Hospital Southampton NHS Foundation Trust
Friends and family test performance (postnatal ward), University Hospital Southampton NHS Foundation Trust

From May 2017 to May 2018 the Trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

In the most recent month, May 2018, performance for postnatal wards was 94% compared to the England average of 95%.

Friends and family test performance (postnatal community), University Hospital Southampton NHS Foundation Trust

From May 2017 to May 2018 the Trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

In the most recent month, May 2018, performance for postnatal community provision was 98% which was the same as the England average.

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017

The Trust was one of the best performing Trusts for two of the 14 questions and were about the same for the remaining questions in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</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>8.13</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>7.91</td>
<td>About the same</td>
</tr>
<tr>
<td>Category</td>
<td>Question</td>
<td>Rating</td>
<td>Comparison</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<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>9.66 About the same</td>
<td></td>
<td></td>
</tr>
<tr>
<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>8.83 About the same</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.33 About the same</td>
<td></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>8.17 About the same</td>
<td></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>8.59 About the same</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>9.66 Best performing Trusts</td>
<td></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>8.40 About the same</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.68 Best performing Trusts</td>
<td></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>9.08 About the same</td>
<td></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>7.29 About the same</td>
<td></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>7.78 About the same</td>
<td></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>8.66 About the same</td>
<td></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>8.38 About the same</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

- Women and their families were encouraged to complete the maternity friends and family test. Staff had worked to increase the response rate using technology. This had seen the response rate increase from 21% in August 2018 to 50% in November 2018. The increase response rate has seen a slight reduction in positive comments however 88.6% of women would recommend the maternity services to others.

**Emotional support**

Staff supported women to cope emotionally with their pregnancy, birth, postnatal care and treatment.
- There were arrangements in place to support women and their families following bereavements and women had access to specialist bereavement team leads.
- Bereaved parents were supported and the unit had a dedicated room with cold cots by their bedside to allow women and their families to have time with their babies in hospital. Babies stayed in the unit instead of the mortuary.
- The maternity service had a specialist midwife who offered bereavement support. The service worked closely with SANDS (still birth and neonatal death charity) who provided the unit with memory boxes.
- Women were asked about their emotional well-being at ante-natal and post-natal visits and received support from the specialist teams as needed.
- Women were monitored and had access to mental health support. There were two family care advisors who offered a counselling service for parents whose babies were in the neonatal unit.
- Clinical midwife specialists were available to advise and support women and staff.

The care records contained assessments for anxiety and depression and staff explained risks and benefits of different options of care and recorded the decisions in women’s records.

Understanding and involvement of patients and those close to them

Staff involved women and those close to them in making decisions about their care.

- Staff encouraged women and their family members to be partners in their care and in making decisions. We observed staff spending time talking to women and those close to them.
- Women were given the opportunity to choose where they had their babies to meet their needs. Any clinical risks were explained as part of the decision-making process and they were supported.
- The women we spoke with told us they had felt fully involved in their care. Staff shared information with them and women were encouraged to ask questions in order to make an informed choice.
- Women attending the clinics told us they needed blood tests for gestational diabetes and were fully informed about the process.
- We spoke with women’s partners who felt the staff had involved them in the care and one person told us they felt ‘part of the team’.

Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy

From October 2017 to March 2018 the bed occupancy levels for maternity were generally lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.
Number of clinical transfers of women and babies from New Forest Birth Centre

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfers from NFBC</td>
<td>4</td>
<td>11</td>
<td>9</td>
<td>7</td>
<td>12</td>
<td>8</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>PPH(^1)/suturing/BP(^2) etc</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PN(^3) transfers for baby</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Transferred in 1st or 2nd stage</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Transferred in 3rd stage</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

- The New Forest Birth Centre (NFBC) is a midwife-led unit and accommodated women who were assessed at the ante-natal stage as low-risk. Women we spoke with confirmed that they were aware that they may need to be transferred to the main hospital site at Princess Anne if they developed any complications.

---

1. Post-partum Haemorrhage
2. Blood pressure
3. Postnatal
Data we received from the Trust showed that a proportion of women admitted to NFBC were transferred to the labour ward. These were clinical transfers; the most common type of transfers was delay during the first or second stage of labour. One woman had post-partum haemorrhage (excessive blood lost following birth), two women required suturing and three were post-natal transfers.

Meeting people’s individual needs

- Midwives identified women with mental health needs through the antenatal screening clinics. They referred those with moderate to severe mental illness to specialist perinatal mental health teams in the community or to a local mother and baby unit. There were clear guidelines for referral mental health support and access to the learning disability teams.
- The service had a dedicated team and an en-suite bereavement room to support women who had experienced lost their babies. This allowed them to spend time with their families.
- There was a separate quiet room known as “Kitty’s” for bereaved parents and their families.
- Improving the experience for longer term patients by providing parent education classes, Wi-Fi access and providing alternative menus to provide a wider choice of meals.
- Working closely with the neo-natal unit the Trust provided accommodation for out of area women and their families whose babies were being cared for in the neonatal unit so parents could remain close to them.
- The Trust had set up a needing extra support midwife team (NEST) who worked with women with complex needs and their families and provided support to those with mental illness, substance misuse or homelessness.
- The midwives assertively outreach the women in the community and encouraged the women to engage. The midwives have a caseload of women and saw this through to birth and follow-up for 15 days.
- The Trust had access to translation services available for women whose first language was not English. Staff confirmed this could be accessed out of hours.
- We saw a case study which supported a woman with learning disability and mental health issues.
- Consultant midwives supported the midwives and women in advocating for non-intervention and normalising births when indicated.
- There were arrangements to support women expecting multiple births. The maternity service had clear guidelines for multiple births. This included guidance through the whole pathway from ante-natal labour and post-partum care.

Access and flow

- The Trust reported there were 5626 births in 2017 across the maternity services which was slightly down from 5749 in 2016. The Trust data indicated that demand has remained stable on the service with a similar volume of deliveries over the past two years, although there were fewer births in 2018.
- The Trust believed they have improved upon the previous inspection with potentially improvements to patient safety however it was unclear if there was specific data to support this.
- There was no waiting list for women to access needing extra support team (NEST) or safeguarding midwife teams.
• All referrals were triaged by midwives before allocation to NEST team. A NEST midwife commented “We offer complete continuity for our families”.
• There was an internal procedure that staff followed for women who missed their appointments, they were initially rebooked and followed up as home visit by community midwives.
• Women had access to the labour line, midwives triaged women and offered support and advice which included early labour. One woman told us they had used this service which meant they helped them decide when to attend the unit and said the staff were helpful and provided reassurance.

Learning from complaints and concerns

Summary of complaints

From September 2017 to August 2018 there were 26 complaints about maternity. The Trust took an average of 51 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 35 working days. IT

The top three subjects of complaint were ‘Attitude of nursing staff/midwives’ (four), ‘Communication with the patient’ (four), and ‘Mismanagement of labour’ (three).

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

Number of compliments made to the Trust

From September 2017 to August 2018 there were four compliments within maternity.

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

• Between April 2018 to November 2018, there were 17 complaints and complex concerns. Eight complaints were partially upheld, two complaints were not upheld, six complaints were closed and one complaint was still open.
• The Trust told us told us that in the period between October 2018- January 2019. There was no case outside their target.
• Information on how to raise concerns or complaints were available to patients. The maternity services circulated a monthly “Experience of care” divisional performance report presented as a dashboard. This also included positive experiences of care.
• Staff knew how to handle complaints. Staff told us they tried to deal informally with concerns and to do this promptly to provide a timely resolution to concerns. Informal complaints were logged and tracked as well as formal complaints.
• Patients could raise their complaints through Patient Advice and Liaison Service (PALS) and formal were shared with maternity leads.
• The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared with staff. These were not completed in a timely way; detailed responses had resulted in delays for the complainants which the Trust was working to improve.
The trust told us that women and their families were encouraged to raise concerns through both the ‘Now is the Time to Ask’ poster and through the ‘Safety Champions’ poster.

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.

- The midwifery leadership structure comprised of director of midwifery with the senior midwifery manager, midwifery matron and midwifery quality assurance manager reporting to them
- We found that the maternity teams were a cohesive team and had senior midwives in position. The managers were visible within the service during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support and leadership. All staff we spoke with, commented positively on this.
- The team leads had the skills, knowledge and experience to perform their role. They demonstrated a comprehensive understanding of the services they managed. All the managers we interviewed had been offered leadership development opportunities, such as coaching skills and managing a budget.
- Most staff knew who the senior managers and executive directors were. They had met the chief executive and executive and non-executive directors. Staff said they had raised issues with senior managers and felt they had been heard and action had been taken. All staff said they could raise issues with their manager if required and action would be taken.
- Managers encouraged and supported innovation, for example, the development of the midwife led pathway and the obstetric led pathway.
- The Trust had employed two consultant midwives to support the midwives in their work.
- Managers ensured midwives and obstetric staff developed safety practices when involved in the performance of invasive procedures, as set out in the national standards for Invasive Procedures (NatSSIPS). These national standards covered all invasive procedures including those performed outside of the operating theatre.

Vision and strategy

- The vision for the maternity service was aligned to ‘Better Births’, the report of the National Maternity Review, published by NHS England in 2016 and the Maternity Transformation Programme
- 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;
- They were working in increasing the proportion of women choosing to give birth in midwifery led units or home births and supporting women to make informed choices.
• The Trust was developing a single maternity electronic patient record for all women and babies. Improving outcomes for women and babies and to include a decrease in infant mortality.
• The Trust told us the maternity service was working with other partners to develop a public maternity dashboard.
• The Trust’s vision and values were on display in all areas. Staff understood the Trust’s vision and values and how these were applied in the work of their teams. The Trust’s senior leadership team had successfully communicated this to front line staff through regular updates, bulletins and clear communication processes.
• All midwives commented positively about the Trust and said they fully upheld the vision and strategy of both maternity services and the Trust. “We put women first, work superbly well as a team and strive for improvements” (midwife). “We feel very much a part of this organisation” (midwife)
• The Trust staff strategy plan 2018 was to have excellent core Human Resources services to ensure speed, simplicity and fairness, whilst maximising opportunities for productivity and flexible responsiveness.

Culture
• The staff respected patients’ diversity and human rights and staff had received training on equality and diversity. Attempts were made to meet people’s individual needs including cultural, language and religious needs.
• The staff we spoke with which included midwives, support staff and obstetricians described their culture as being supportive and approachable colleagues. They described the team as an inclusive and supportive. The staff we met told us they felt cared for, respected and listened to by their peers and managers.
• The Trust scores for staff formally reporting incidents of harassment, bullying or abuse had improved since the 2015 results (43% in 2016 from 37% in 2015). The Trust remained below average compared to other acute Trusts in these areas (45%).
• Senior managers told us that they recognised that these were areas where the needed to improve. The Trust was on a trajectory of sustained action over a longer period in order to make the required cultural and behavioural improvements they wished to achieve. The action plans into 2017/18 was to continue to focus on the areas of greatest concern for their staff.
• The data highlighted that the experiences and opportunities for BME staff were less favourable compared to white staff. The Trust reported there had been marginal positive improvements year on year, the pace was slow and there was still a considerable way to go before the Trust truly achieved race equality.
• The highest levels of discrimination were reported by their BME staff (26%), those from disabled staff (16%) and by men (14%). (UHS Staff Survey Result 2016).
• The trust was aware of the need to develop the equality and diversity further in the trusts day to day work and for supporting opportunities for career progression. The trust was working on feedback from the staff survey where some staff groups felt they were not treated as equals.
• The Trust had developed their Freedom to Speak Up (FTSU) guardian initiative. The Trust had received 25 cases since the appointment of the FTSU guardian in October 2017. The Trust received 13 FTSU cases from April to September 2018.
• The Trust hosted a regional FTSU meeting on the 13th November 2018 with representation from the National Guardian.
• The NHS Improvement/FTSU office self-review tool undertaken by the Trust was discussed at the Trust board study session in July 2018. The review identified some action points which included:
  1) Develop a FTSU vision and strategy
  2) Communicate the FTSU message
  3) Establish a network of FTSU Champions
  4) Share lessons learnt

A summary of all cases received since the appointment of the FTSU Guardian (October 2017) is detailed below-

<table>
<thead>
<tr>
<th>Category</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
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<tbody>
<tr>
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<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Breach of Confidentiality</td>
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<tr>
<td>Bullying and Harassment</td>
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<td>Concern over HR process</td>
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<td>1</td>
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<tr>
<td>Discrimination</td>
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<tr>
<td>Patient Safety Issue</td>
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<td>2</td>
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<td>Policy Implementation</td>
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<tr>
<td>Recruitment</td>
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<tr>
<td>Team Dynamics</td>
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<tr>
<td><strong>Total</strong></td>
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</table>

**Governance**

• There were governance and assurance meeting, performance meetings, divisional governance and assurance meeting and divisional management executive meeting 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.
• The midwifery quality assurance manager monitored and reported to the maternity governance committee and the clinical effectiveness committee. This information was reported to the head of clinical governance.
• Mandated training for maternity staff were formally approved through Women and Newborn Governance Steering Group.
• There was a monthly MQUEST meeting Maternity, Quality, Education and Safer Together (MQUEST) which has replaced the Perinatal Morbidity and Mortality meetings. An MQUEST messenger was produced following the meeting which was circulated via email to all maternity staff and was displayed in some areas.
• Staff we spoke with said they raised any quality issues to their managers who reported them to the Matron to escalate at the senior leadership meetings to be discussed.
• There were regular staff meetings and newsletters for sharing information and updates which were cascaded up and down through the service. There were regular agendas or risk meetings and the minutes were distributed.

• Senior midwife representatives and the divisional governance manager attended the Trust monthly quality governance steering group.

• Senior midwives had access to their team’s performance dash boards so could monitor their team’s key performance indicators and key risk issues.

• The maternity teams used the boards daily in handover and clinical meetings. The electronic system triggered risk incidents, for example, excessive blood loss, eclampsia, hysterectomy, deep vein thrombosis and any fatality.

• The Trust had initiated a leadership development programme be shaped around their vision and values to deliver resilient, compassionate, forward-thinking and capable leaders needed for the future.

Management of risk, issues and performance

The maternity service had systems in place for identifying risks, planning to reduce them.

• The maternity service had one risk register which incorporated the ante-natal, post-natal and delivery suites. The risk register was reviewed monthly by the care group manager and risk lead and on a quarterly basis at the Maternity, Neonatal and Women’s Services Governance Groups.

• The service had signed up to a number of work streams to review maternal deaths, stillbirths and infant deaths that included:
  Each Baby Counts –Royal College of Obstetricians and Gynaecologists national quality improvement programme to reduce the number of babies who die or are left severely disabled because of incidents occurring during term labour. This worked alongside NHS Resolutions’ early notification scheme.

• Saving Babes Lives – designed to tackle stillbirth and early neonatal death.

• The maternity service has undertaken a staff SCORE Safety Culture Survey to establish the culture within the maternity service teams. This would help the Trust in identifying team cultures and provide resources to support safe care.

• Information was available and key messages related to quality and risk. Changes were shared by email, lessons of the month, and there was a monthly presentation of the top risks in the service on the midwifery study days.

• Potentially serious or high-risk incidents were scoped within 72 hours and reviewed by the quality and risk manager, clinical service lead and head of midwifery and any immediate actions taken as required.

• The trust told us the maternity service has undertaken a staff Safety Culture Survey in 2018 to establish the culture within the maternity service teams. This would help the Trust in identifying team cultures and provide resources to support safe care.

• The Trust said they had developed their social media service in the last year where they shared information with women.
• The trust had told us that they had a ‘Safety Improvement Plan’ in place to support the drive to improve quality, reduce risk and to improve outcomes for women and babies.
• The Trust told us the maternity service ‘Maternity Safety Champions’ in place at both maternity and executive level who meet monthly to discuss current and on-going safety issues within the service.
• The Trust told us they were part of the Maternal and Neonatal Health Safety Collaborative, and staff had access to quality improvement training and expertise and enabled the team to work collaboratively to improve clinical practices.

Information management

• The risk register had identified that risks of under reporting of incidents due to the lack of availability of IT remote access. It also showed that IT provision and support was not currently provided for the community localities and there was no ability for printing information. The risks were that information may not be available to staff and staff had to travel to the main hospital site in order to record incidents.
• The Maternity Service currently had a record system called Hospital Integrated Clinical Support System (HICSS) where important pregnancy information was recorded. Within HICSS there was a requirement for the midwife to record if a FGM had been disclosed and the type of involvement necessary. This information was captured at booking and at birth.
• The national trajectory is for 20% of women to be booked onto a pathway that provides continuity of care by 2019. The Trust is part of the Local Maternity System (LMS) responsible to deliver on the recommendations of current national maternity strategy. The maternity unit at Southampton together with Hampshire, Isle of Wight and Portsmouth (SHIP) had developed a shared vision and Local Maternity Transformation Plan and proposed to deliver these recommendations by 2020/2021.
• The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and measures against national outcomes.
• The maternity dashboard included service performance measures which managers reported on to the board. The maternity dashboard contained information relating to activities such as the number of planned and emergency caesarean sections, perinatal mortality, post-partum haemorrhage and the number of emergency admissions to the service.

Public engagement

• Women and their families were encouraged to complete regular surveys to provide feedback on the care they had received. Themes of concerns and complaints and feedback from the ‘friends and family test’ survey was reviewed regularly.
• The maternity service participated in a domestic violence awareness week. The specialist midwife sat on the multi-agency domestic violence forum with police, probation, women’s aid, and victim support. A newsletter was prepared by this forum and circulated monthly.
• Staff worked with local people and the council to create a “breast feeding friendly” city. Also contributed to world breast feeding day in conjunction with health visitors and the NCT.
• The maternity unit ran a birth “after thoughts” initiative which invited mothers to come back to the maternity unit at any time after the birth of their baby to discuss their experience.
Each mother was given a bookmark with contact details for the unit. Women could ask questions, provide meaningful feedback or raise any concerns.

- The friend and family test results showed that 93% of women would recommend the service to family and friends. 95% would recommend the labour ward and birthing units, 88% the post-natal wards and 83% would recommend the community service to friends and their families.

**Staff engagement**

- The staff strategy plan 2018 for the Trust and their three main values of patients first, working together and always improving. Culture has been internally and externally recognised as being positive, but need to go further in order to fully maximise our potential.
- The 2017 staff survey results showed 86% of UHS staff said patient care was the top priority and 76% would recommend UHS as a place to work. Also 57% of staff said they had enough equipment to carry their jobs and 33% of staff said there were enough staff to meet the needs of patients.
- The Trust had developed an action plan in response to the staff results and there were other workstreams in progress such as work “after thoughts” sessions for staff to make suggestions for improvements and mindfulness sessions for staff.
- Theme of the week was circulated to all staff highlighting lessons learnt either from an accident or complaint.
- The service had communication folders which were available updating staff on a variety of topics. The trust told us that regular ‘themes of the week’ posters were used to raise awareness and promote safety culture.
- Daily meeting occurred on Labour Ward to discuss any cardiotocography issues and opportunity for debriefing for staff.

**Learning, continuous improvement and innovation**

- Staff contributed to the on-going development of services and implementations of new ways of working. Staff were confident in explaining how they delivered high quality care, support and treatment within a defined budget.
- Quality improvement projects included action plans to address the five national safety priorities which were: Improve smoking cessation rates (dedicated specialist smoking cessation midwife), management of neo natal hypo glycaemia, recognising any deterioration of mother and baby, stabilisation of the pre-term baby and stabilising diabetes in mothers.
- The Trust had developed the home birth team in October 2018 for all low risk women.
- Another quality improvement project was set up looking at improving the early recognition and management of deterioration of either mother or baby during labour. Also, empowering women and staff to speak up and ask questions and improving the stabilisation of preterm babies.
- The research midwives were carrying out a randomised controlled trial comparing two different types of sutures.
- Another trial of a pessary looking at the prevention of per-term birth in twin pregnancy and working to understand how nutrients were transported across the placenta.
- Women were encouraged to express colostrum pre-birth.
- The trust was working on reducing the rates of stillbirth, neonatal death; maternal death and brain injury during birth by 20% by 2020 and are on track to make a 50% reduction by 2025. The Trust are investigating and learning from incidents and sharing this learning through their Local Maternity System and with others.
- The national apprenticeships agenda, coupled with new frameworks for the training of healthcare professionals, provided the Trust with a platform to deliver education in partnership with new and emerging education providers who are entering the market. Traditional direct entry via degree based healthcare education will remain an important entry point into the NHS.
Acute services

Maternity (New Forest Birth Centre)

Facts and data about this service

This report relates to the service provided at the New Forest Birthing Centre (NFBC) which is a stand-alone service in the New Forest. The staff worked collaboratively with Princess Anne Hospital which is the main maternity centre for this Trust.

Maternity Services at the Princess Anne Hospital is a tertiary provider of complex maternity and neonatal services including high risk maternal and fetal medicine and infants with complex medical and surgical needs. Births occurred in four locations: Labour Ward, the midwifery-led low risk birthing areas in the co-located Broadlands Birth Centre, stand-alone New Forest Birth Centre, and the home setting.

The maternity service included hospital and community settings ensuring that women received care across the antenatal, labour and postnatal periods. The service comprised of the pre–natal diagnostic service such as medicine, antenatal screening facilities and the Ultra Sound Sonography (USS) service.

Maternity services at Princess Anne provided unscheduled and emergency service alongside planned and responsive community acute care delivery. 75% of the service was delivered within a community setting with care being provided in hubs in Hedge End, Royal South Hants and the New Forest Birth Centre. Community services were also delivered within Children’s Centres, GP surgeries and the home environment, with approximately 51,000 antenatal contacts and 21,000 postnatal contacts. The Trust has 80 maternity beds.
During this inspection, we visited the New Forest Birthing Centre (NFBC), a free-standing midwife-led unit on the edge of the New Forest. It has seven labour and post-natal beds including two birthing pools. This service provided care to low risk women and babies.

Uncomplicated pregnancies were midwife-led throughout pregnancy and birth and the care of women with specific complications were managed by the midwives and the obstetric team using agreed pathways and guidelines.

The midwives were organised into two teams delivering either midwifery or obstetric led care. This ensured that the workforce could respond flexibly to the demands of the service and maintain the skills of the midwifery staff working within each pathway.

Women were offered antenatal clinics with specialist midwives to support women with their varied needs. The Trust had a day assessment unit where women requiring advice and treatment were triaged; staff were able to perform scans as outpatients, avoiding admissions and enabling women to return for checks if required.

The Trust told us that maternity services worked to ensure that the vision from Better Births was embedded into service development to ensure it was safe, well-led and met the needs of women.

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings.

During this inspection we spoke with 28 staff members across maternity services; including service leads, matrons, midwives, health support staff, midwives, domestics and administrative staff.

- We spoke with 12 women and their relatives and reviewed approximately 48 records across maternity wards including care plans, risk assessments, medicines charts and other records pertaining to the service.

(Source: Acute Provider Information Request – Context tab)

From January 2017 to December 2017 there were 5,352 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 babies delivered at University Hospital Southampton NHS Foundation Trust – Comparison with other Trusts in England.**

A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

### Profile of all deliveries (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5,212</td>
<td>98.3%</td>
</tr>
<tr>
<td>Multiple</td>
<td>88</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>144</td>
<td>2.7%</td>
</tr>
<tr>
<td>20-34</td>
<td>4,046</td>
<td>76.3%</td>
</tr>
<tr>
<td>35-39</td>
<td>889</td>
<td>16.8%</td>
</tr>
<tr>
<td>40+</td>
<td>221</td>
<td>4.2%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td>5,300</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 (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Gestation period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre-term 24-36 weeks</td>
<td>362</td>
<td>7.0%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>4,803</td>
<td>92.9%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td></td>
<td>5,171</td>
</tr>
</tbody>
</table>

**Source:** Hospital Episode Statistics, April 2017 to March 2018
Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with ‘***’ (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the Trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at University Hospital Southampton NHS Foundation Trust by quarter.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

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

Trust level

A breakdown of compliance for mandatory training courses from September 2017 to August 2018 at Trust level for qualified nursing staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</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>Hand Hygiene</td>
<td>291</td>
<td>292</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major Incident Planning</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>289</td>
<td>292</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>286</td>
<td>292</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>279</td>
<td>292</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>274</td>
<td>292</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>268</td>
<td>292</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>264</td>
<td>292</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>263</td>
<td>292</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>28</td>
<td>37</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for nine of the 10 mandatory training modules for which qualified nursing staff were eligible.
A breakdown of compliance for mandatory training courses from September 2017 to August 2018 at Trust level for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</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>Adult Basic Life Support</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

Midwifery and medical staff were given protected time to complete training in skills specifically required for maternity.

- The Trust had in place a training programme and the staff were expected to complete the mandatory specific training. Staff also completed additional training as part of their practice and to meet the requirement of registration with the nursing and midwifery council (NMC). These included recognition of the deteriorating women, resuscitation of the new-born, obstetric skills, cardiotocograph (CTG) and drills of emergency scenarios and other sessions according to service needs identified from risk or incident themes. We requested the Trust target for attendance at the obstetric skills training, we did not receive this information, which meant we could not report whether the compliance rate for this training had been met.
- Staff told us 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).
- 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 was based in the hospital unit using hospital equipment so staff had local knowledge of how to deal with emergencies.
- Staff had completed K2 training which was a perinatal training programme in fetal monitoring.

Safeguarding

Staff were aware of processes and standard procedures to keep people safe from abuse. Staff received training to assess, recognise and report abuse.

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

A breakdown of compliance for safeguarding training courses from September 2017 to August 2018 at Trust level for qualified nursing staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</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>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>276</td>
<td>289</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>31</td>
<td>37</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to August 2018 at Trust level for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</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 2)</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

- There were safeguarding policies and procedures which staff were confident in using to safeguard women and babies as required.
- Between December 2017 and December 2018, the Trust told us maternity services had 38 cases were input into the NHS Digital FGM database. This is a dataset which supports the Department of Health’s female genital mutilation prevention programme by presenting a national picture of the prevalence of FGM in England. There were 11 cases sent for information sharing with Children’s Social care in accordance with the risk assessment and local/national guidance.
- The maternity service at the Trust had made 110 Multi Agency Safeguarding Hub (MASH) contacts across Hampshire and Southampton Children’s Social Care.
- Maternity service had a specialist team of safeguarding midwives which included lead midwives for domestic violence, safeguarding, newly appointed female genital mutilation lead midwife, a peri-natal mental health midwife and a substance misuse lead midwife. Staff told us that safeguarding was part of their daily practice and assessments of women were given high priorities.
• All staff we spoke to knew how to raise safeguarding issues or concerns. Staff said they completed an electronic incident form and informed the midwife in charge or the safeguarding specialist midwife team. All staff were aware of who the Trust’s safeguarding lead was and how to contact them.

• Staff were aware and how to report female genital mutilation (FGM) and spoke to us about safeguarding women and their female children. 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.

• We saw other information was available at the Trust such as a checklist for first disclosure of FGM and action staff should take and including informing the police, if a child was under 18 years of age.

• The Trust had procedures in place for all women and girls with acute or recent FGM requiring police and social services referral via the Maternity Safeguarding team. Two staff members we spoke with were aware of the actions they would take. A staff member told us they would also contact the safeguarding midwife for advice.

• Safeguarding training in FGM was available to midwives and staff said was very useful as it included referrals processes.

• Safeguarding drop in sessions were held by the safeguarding team at regular intervals in the main hospital which midwives attended.

• The safeguarding team provided training to other staff, case supervision, helped and advised on risk assessments as needed.

• A representative from the safeguarding team was a member of the multi-agency safeguarding hub. They attended regular reviews were cases were discussed and cascaded information to the other midwives as part of learning from incidents.

Cleanliness, infection control and hygiene

The infection control measures to prevent the spread of infection was consistently followed.

• All areas we visited at the New Forest Birthing Centre was clean, tidy uncluttered and well maintained.

• There was a system to identify equipment that had been cleaned and ‘I am clean stickers’ were used. There was a room cleaning form in the birthing pool rooms which was completed and this identified the birthing rooms were clean and ready to use.

• There were guidelines for effective infection control which staff followed including the birthing pools where the outlet and taps were flushed and records maintained to inform practices.

• The staff observed bare below the elbows procedures when working in the clinical environment. Hand gels were available at the entrance to the unit although there was a lack of signage to advise visitors to use hand gels when accessing the unit and the wards.

• Midwives who worked in the community and attending home births were provided with hand sanitiser, personal protective wear required to ensure effective infection control procedures were adhered to.
There was no MRSA or clostridium difficile cases reported in the maternity services. MRSA is a bacterium responsible for several difficult-to-treat infections and clostridium difficile is an infective bacterium that causes diarrhoea.

Environment and equipment

The environment and emergency equipment were maintained safely as all necessary checks were completed.

- At NFBC emergency equipment was well maintained and records of checks seen confirmed that these were carried out daily in line with Trust procedures.
- The environment was well maintained including the two birthing pools which were bright and airy and the women and their partners were complimentary about the facility. There was a variety of equipment including resuscitare to meet the needs of women and babies.
- There was controlled access to the service and there was a receptionist at the desk during office hours. There was a procedure in place for out of hours access to the unit and the intercom system as all doors were locked. Staff told us that security of the unit was discussed regularly. Staff felt that the measures were adequate due to the low number of visitors to the service and this was monitored.
- We had raised some security concerns across maternity services and at the main site with the senior management. Following the inspection, the Trust told us that they were developing a missing baby policy which was in draft, which meant currently there was no policy for staff to be working with. We received a copy of the policy following the inspection.

Assessing and responding to patient risk

- Staff used an overarching risk assessment tool for all families. This had been agreed across many agencies and was published by the multi-agency safeguarding children’s board.
- Areas of risk factors included, all young women under 16, any women known to adult or child safeguarding, any women with alcohol or substance misuse issues, any looked after child or care leaver.
- Other groups included homeless women, asylum seekers, illegal immigrants, refugees, any trafficked women, those at risk of exploitation (including sexual), women with a learning disability, and those women with mental health issues.
- Women experiencing domestic abuse, and those women having undergone female genital mutilation (FGM) were referred to the specialist midwives team for advice and support.
- We saw antenatal risk assessments and screening for safeguarding and mental health had been completed.
- Women were assessed for risks of venous thromboembolism (VTE), blood clots and risk assessments were completed for all women in the records we looked at. The compliance rate was 83%.
- Midwives monitored women’s baseline observations such as blood pressure, weight and fetal growth at each appointment. They reassessed risk factors as appropriate. The risk assessment process included an escalation procedure to refer women to an obstetric consultant team. These included women with increased risks of high blood pressures and gestational diabetes.
• Midwifery and obstetrics staff completed the modified early obstetric warning score (MEOWS) system to record observations. This was being used as standard baseline observations of women on admission to the unit.
• Phased assessments and care plans were in place over pregnancy. Initial assessments included MEOWS and blood tests. At 34 weeks an emotional wellbeing assessment was drawn up and care plans for birth were initiated.
• The community midwives carried out new-born and infant physical examination screenings (NIPE) within 72 hours, to identify any developmental risks. All high-risk women had a named midwife and consultant which ensured continuity of care through pregnancy and post-partum care.
• Arrangements were in place for transfer of women to the main site at Princess Anne Hospital such as those requiring intensive care, post-partum haemorrhage or for interventional radiology.
• The Trust had introduced triage midwives which allowed for direct referral from women and GPs into the maternity service. This enabled the service to have an early contact with the women to highlight any actions or referrals needed.
• Staff attended sepsis training annually and could describe the sepsis screening and their escalation process for medical support and transfer of women as needed.
• The birthing unit followed SBAR (situation, background, assessment, recommendation) format, a technique used to facilitate prompt and appropriate communication if they needed to transfer women to another unit.
• Staff at the New Forest Birthing Centre (NFBC) followed the Trust policy for the transfer of women in labour to a consultant led unit including the management of women or babies who showed signs of deterioration and required additional care.
• Between January 2018 to November 2018 there were 99 clinical transfers from NFBC to the Princess Anne Hospital.

Midwifery and nurse staffing

• At the NFBC the duty roster consisted of a band 7 or 6 midwife and one health care support worker. Staff told us they would contact the main hospital if they needed further assistance. Women at the NFBC used the birthing pools and it is recommended that two midwives should be present for the birth. One of whom must be experienced in caring for women labouring and giving birth in water. This may pose safety risk for women and babies as support from the Broadlands centre may not be available in time.
• The NFBC did not display their staffing numbers as recommended. Staff told us they did not use agency staff and relied on their bank and support from Broadlands Centre at Princess Anne Hospital as needed to cover any sickness and absence.
• Following the inspection, the Trust told us there was no woman in labour and one of the midwives was working in the community and would have returned if needed.
• The Trust had two consultant midwives in post. These were qualified midwives who had received further development through academic and practical clinical experience enhancing their midwifery skills to become experts in midwifery practice and leadership.
• The Consultant midwives were responsible for providing clinical support to midwives and women along the midwifery led pathway. They contributed to the governance of the service as leads for audit and clinical effectiveness. The Trust told us they offered supervision and support to midwives and played an active role as advisors to the senior programme and hosted the trainees within the four-year programme.
• The Trust’s needing extra support team (NEST) worked within community areas and offered a ‘named midwife’ for a case load of women. The NEST midwives provided antenatal, intrapartum and postnatal care in the unit, birth centres or in the community.

• Those families with socially complex needs fell within the needing extra support team (NEST) remit and this increased demands on midwifery time, in relation to safeguarding and child protection. Staffing was planned in recognition of this and this team had fewer women on their case load midwifery than that of a midwife with a universal caseload.

• Staff told us that the NEST team was invaluable in providing support to women and staff. However there had been some challenges with sickness and recruitment to the NEST team. The Trust had put in a plan to address this by offering all women who were planning a home birth to be cared for by the NEST team. This would increase the diversity of women cared for by the NEST team and widen the interest group of midwives who were eligible to apply for these posts. The Trust has also purchased external clinical supervision to this group of midwives, to enable them to reflect and receive support in their roles.

• The Trust had recruited 43 new midwives in the preceding 18 months. Staff told us that they felt there were enough staff most of the time to deliver care safely and effectively.

Planned vs actual

The Trust has reported their staffing numbers below for August 2018.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Scheduled</th>
<th>WTE in post</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princess Anne Hospital</td>
<td>251.31</td>
<td>257.10</td>
<td>102%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From September 2017 to August 2018, the Trust reported a vacancy rate of -7.3% in maternity. This was lower than the Trust target of 12%. The negative figure indicated that there were more midwives in role than had originally been scheduled.

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

Turnover rates

From September 2017 to August 2018, the Trust reported a turnover rate of 11.1% in maternity. This was lower than the Trust’s rolling 12 months target of 12%.

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

Sickness rates

From September 2017 to August 2018, the Trust reported a sickness rate of 4.2% in maternity. This is higher than the Trust’s rolling 12 months target of 3.5%.
Bank and agency staff usage

From September 2018 to August 2018, the Trust reported that 3.5% of qualified nursing shifts in maternity care were filled by bank staff and 0.0% of shifts were filled by agency staff.

Midwife to birth ratio

From April 2017 to March 2018 the Trust had a ratio of one midwife to every 22.89 births. This was lower than the England average of one midwife to every 25.68 births.

Never Events

From August 2017 to July 2018, the Trust reported no incidents which were classified as never events for maternity.

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.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the Trust reported four serious
incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2017 to July 2018.

The breakdown of the types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with 2 (50% of total incidents).
- Pressure ulcer meeting SI criteria with 1 (25% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with 1 (25% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Records

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

- There was a mixture of paper and electronic (E) records in use at the Trust. Senior managers told us the aim was to introduce E records although they said this was work in progress.
- In the labour wards, records were maintained electronically which included partogram (graphical record of key data (maternal and fetal) recorded on a single sheet during labour) and Cardiotocography (CTG) which recorded the fetal heartbeat and uterine contractions during labour.
- We looked at six care records and each stage of the maternity pathway had an agreed proforma completed which included a prenatal module, a labour module, a theatre module and a postnatal module.
- Although some women’s records were fully completed, there were some inconsistencies in assessments such as venous thromboembolisms (VTEs) were not completed in three out of five records.
- The maternity risk register updated in September 2018 had identified women observations at a critical stage in labour; aspects of basic care and key observations were not being recorded in line with guidance. The Trust had developed an action plan which included holding a second stage of labour workshop and re audit in six months.
- Women received the personal health record the ‘red book’ to keep details of their baby’s development and took with them to all future baby appointments and reviews. Women and babies’ records were stored securely.
Records showed staff had completed a comprehensive assessment including, where appropriate, physical health, mental health and any social needs of patients.

Care plans reflected the individual woman’s needs that staff had identified during the initial assessment. Care plans were personalised, holistic and recovery focused, risk assessments and results were documented.

Staff raised some concerns about the current process of scanned records as once scanned these were destroyed. We were told that the quality of the scanned records was sometimes in the wrong order making risk assessments and investigations a longer process, and risks of vital information being missed.

The current process did not allow for patients’ E records to be seen by other departments. When referrals and second opinions were sought, these were documented on paper although all other patients’ notes would be electronic at that point.

On discharge home, an electronic summary was sent to the GP, the Health Visitor and the records were scanned into the Trust record system.

Women continued to have a hand held maternity record as midwives were unable to easily access results and e-documents when working in the community.

A senior manager told us that the Trust was working towards E- record in 2019, this was being progressed through the Southampton, Hampshire, Isle of Wight, Portsmouth (SHIP) Local Maternity System programme.

**Medicines**

**The service followed best practice when prescribing, giving and documenting medicines.**

- Midwives administered and supplied medicines against Patient Group Directions (PGDs) and in line with maternity exemption (ME) protocols. Patient Group Directions (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 midwife 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 supported staff and provided training and were authorised to work to PGDs and ME. The Trust had a process to ensure PGDs and ME protocols were reviewed regularly.

- The service received timely supply of medicines and had access to medicines when the pharmacy was closed. Staff said they received good clinical pharmacy support.

- At the New Forest Birthing Centre (NFBC) the staff undertook a weekly medicines order to the pharmacy at Southampton General and could request urgent orders on any day. They also had access to the out of hours pharmacist and a good communication system with GPs for prescriptions to be written if a woman needed medicines which the midwives could not supply.

- We carried out a random review of medicines and we did not see any expired drugs in any department. This meant that there was regular drugs reconciliation to ensure women and babies received their medicines safely.

- The midwives collected the medical gas (gas and air for pain relief) cylinders from the unit when attending a home birth. The medication required for the birth of the placenta was collected from the fridge on the unit.
Incidents

- There were 1867 incidents reported during 2017 across maternity services, of which 35 were rated moderate or above and were subject to duty of candour disclosure. 18 serious incidents were reported and subject to a Root Cause Analysis (RCA).
- There was a process for reporting incidents which staff said they felt confident to use and followed their escalation procedures as required. Staff knew how to recognise and report incidents and used the Trust electronic recording system.
- 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 and this could only be completed by coming into the hospital to record.
- Incidents and lessons learnt from incidents were shared at the staff daily handover meetings, regular team meetings and at the monthly risk meetings where all incidents, themes, actions and the risk register were looked at.
- Between March 2017 and December 2018 there were five serious untoward incidents. The main themes of lessons learnt included: midwife skills and observations, handovers, risk assessing and escalation, staffing and culture.
- This was followed up and included a documentation audit day, labour workshop, midwifery back to basics education, breech birth workshops and cascade training, communication improvements, debrief and trauma risk management training.
- The Trust told us they worked collaboratively with the Healthcare Safety Investigation Branch (HSIB) to ensure learning from safety incidents were shared widely.
- Following a root cause analysis related to discharge of a woman, the Trust had introduced triage midwives which allowed for direct referral from women and GPs into the Maternity service. This enabled the service to have an early contact with the women to highlight any actions or referrals needed.
- To assist learning, a “theme of the week” one sheet poster was sent to all staff. For example, we saw one briefing which advertised the emergency calls and cardiac arrest call procedures.
- As part of lessons learnt, the obstetric referral guideline had been recently updated which provided guidance for all staff involved in the referral, administration and management of women requiring antenatal obstetric referral.
- Staff were informed via their internal system such as “MQuest messenger” on a monthly basis, inviting them to a lesson learnt session. For example, in October 2018 staff attended a session looking at a clinical case of a woman who had experienced a placental abruption.
- In addition, monthly communications were sent out to teams called “be on the look- out”, for example, examining case studies looking at the importance of accurate risk assessing.
- Staff understood their responsibilities in relation to the Duty of Candour and told us they were open and transparent with women 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 women (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Safety thermometer

- The maternity safety thermometer is a measurement tool for improvement that focuses on
incidents such as post-partum haemorrhage (excessive bleeding during/after labour), infection, separation from baby, perineal and abdominal trauma, incident of urinary catheters or urinary infections. Any falls and venous thrombo-embolism (VTE) blood clots.

- This allowed the team to take a temperature check on harms associated with maternity care but also reflected the proportion of mothers and babies who had received “harm free” care.
- During the inspection, we did not see any safety thermometer information displayed in the areas that we visited. Information was not available for women and visitors.
- At the New Forest Birthing Centre (NFBC), staff were not aware whether safety thermometer information was collected for their unit.
- The Trust data we looked at during the inspection showed the statutory safety thermometer returns were monitored and included VTE assessments was currently at 83.5%.
- The Trust told us the maternity service was working with partners across the Local Maternity System (LMS) in development of a public Maternity Dashboard which was being tested and would be available to the women.
- The trust informed us that all cases of Perineal trauma (3rd and 4th degree tears) were reported via the internal Incident reporting systems.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- We observed that the care and treatment was managed in accordance with national guidance. For example, 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 Heath and Care Excellence (NICE) guidance.
- The Trust had developed guidelines in line with the World Health Organisation (WHO 2013) to support staff in recognising the types of female genital mutilation (FGM). The aim was to support staff in providing safe care and identify women at risk at an early stage.
- 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.
- Babies born with tongue tie were seen in midwife-led clinics. Several midwives had been trained to treat tongue tie. During our inspection at the NFBC, the lead midwife carried out this procedure on one of the babies.
- Care was tailored to the women’s holistic needs, this was evident from feedback we received from several midwives. Fetal 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.
• Midwives monitored fetal growth using the fundal height measurement (from the top of the mother’s uterus to the top of the mother’s pubic bone), and plotted this using customised growth charts.

• The maternity service also carried out detailed ultrasound in the first and second trimester of pregnancy. They 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.

• Fetal 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 were assessed for jaundice and treated in line with NICE guideline QS57. A new mother told us about the diagnosis and treatment of their baby who had been diagnosed as having jaundice.

• Staff were aware of the latest sepsis guidelines and information included a detailed maternity sepsis screening and action tool in line with NICE guidelines.

• There was a process for senior managers to check that guidance was followed and staff provided care in line with guidelines.

**Nutrition and hydration**

**Women were supported to maintain a healthy diet**

• Women were provided with advice on healthy eating and keeping hydrated during labour. The women we spoke with were complimentary about the food and fluid they received. This was particularly well managed at the NFBC where we observed meal service as part of the visit. Women were offered choices and meals were varied which women said met their needs.

• Staff told us they provided infant feeding support for women in the community if they needed it. There were also baby cafes where women could attend for peer support and further advise.

• The maternity service 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.

• The performance dashboard reported 74% of women initiated breastfeeding during quarter 3 and 77% in quarter 4. This was in line with the England average (Source NHS England 2017).

• Artificial feeds were available to women wishing to bottle feed their babies. 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 maternity services were not accredited with UNICEF baby friendly initiative. They told us they had chosen not to apply for accreditation while it was not mandated.

• 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 women pain and provided information on different types of pain control available to them.**

- Women received information about the type of pain control which would be available to them depending on where they chose to have their babies. Women were offered gas and air and were aware that they would be transferred to Princess Anne Hospital if they required an epidural.
- Women we spoke with said they had received ‘very good information’ and were supported to manage their pain and pain control of their choice was available. They said the type of pain control was discussed during the antenatal stage and they knew they could opt for stronger pain control if they needed.
- The NFBC had two birthing pools were available; other equipment included bean bags and birthing balls to support women during labour.
- Women we spoke with and midwives said pain relief was discussed at ante natal appointments and pain control choices and flexibility for women to change their minds.
- Information was available for women who chose to use alternative pain relief therapy. For example, transcutaneous electrical nerve stimulation (TENS) machines they would need to provide their own.
- The maternity service did not provide any complementary therapies for pain relief.

**Patient outcomes**

- The Trust reported 75% of the service was delivered within a community setting such as maternity hubs in Hedge End, Royal South Hants and the New Forest Birth Centre. This included 51,000 antenatal contacts and 21,000 postnatal contacts delivered in the community.
- The Maternity Services had developed the needing extra support team (NEST) that aimed to provide continuity of the midwife providing care to the woman, throughout the antenatal, intrapartum and postnatal period. Continuity of care was associated with 16% less likely to lose their baby, 24% less likely to have a preterm birth, 15% less likely to have an epidural and 16% less likely to have an episiotomy. (Source: Trust board paper April 2018).
- The maternity service contributed to the Better birth project, the Trust had developed community hubs across Southampton and Hampshire, 98% of women were seen in a community hub.
- The performance dashboard for 2016/2017 showed year to date figures for place of birth: 78% of all births occurred in the obstetric-led delivery suite, 13% in the Broadlands Birth Centre, 5% in the New Forest Birth Centre, 2% were planned home births, and 1% of babies were born before the woman arrived at the hospital.
- Midwives followed a pathway developed for women with raised BMI over 30 which included weight measurements at booking, 16, 28 and 36 weeks, ultra sound scans and dietary advice.

**National Neonatal Audit Programme**
In the 2017 National Neonatal Audit, Princess Anne Hospital performance in the two measures relevant to maternity services was as follows:

- Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 160 eligible cases identified for inclusion, 89.8% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit’s recommended standard of 85% for this measure.

- Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 58 eligible cases identified for inclusion, 56.9% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5%, and put the hospital in the top 25% of other units.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised Caesarean section rates and modes of delivery

From April 2017 to March 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 (April 2017 to March 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of caesarean</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
<tr>
<td>Emergency caesareans</td>
</tr>
<tr>
<td>Total caesareans</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018
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.

In relation to other modes of delivery from April 2017 to March 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>1,390</td>
<td>26.2%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>754</td>
<td>14.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>3,156</td>
<td>59.5%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,300</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.
\(^1\)Includes elective and emergency caesareans
\(^2\)Includes forceps and Ventouse (vacuum) deliveries
\(^3\)Includes breech and vaginal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of September 2018 the Trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The Trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 7.33.

This is up to 10% higher than the average for the comparator group rate of 6.71.

(Source: MBRRACE UK)

- We looked at the data on Insight did not support an improvement to safety with no measures showing an improvement and a deterioration in the stabilised and risk-adjusted extended perinatal mortality rate (MBRACE). The Trust was now worse than the national average for this measure.
- Trusts are required to participate and report on all National Clinical Audit and Patient Outcomes Programme projects as part of their NHS Standard contract. All NHS maternity units in England, Scotland and Wales are therefore expected to participate in the National Maternity and Perinatal Audit (NMPA).
● The Trust was identified as a potential outlier for the proportion of singleton, term, liveborn infants with a 5-minute Appearance, Pulse, Grimace, Activity, and Respiration (APGAR) score of less than 7. The APGAR score is a test given to newborn soon after birth. This test checks a baby’s heart rate, muscle tone, and other signs to see if extra medical care or emergency care is needed. The APGAR score is used to summarise the condition of a newborn baby, typically at 1, 5 and 10 minutes of age. A 5-minute APGAR score of less than 7 has been associated with an increased risk of problems for the baby.

● The Trust was required to undertake a review of the APGAR. The Trust told us they identified some discrepancy in APGAR score allocation and data inputting into the Hospital Integrated Clinical Support System (HICSS). This led to an in-depth audit of the women and babies’ records.

● They carried out an audit of 93 healthcare records to establish whether the APGAR recorded on the hand-written records matched the electronic records. The findings of the audit showed that 6 of the 93 records were incorrect (the written APGAR did not match the electronic record). With the data corrections made the site result changes from 2.3% to 2.1% (Improvement against the National mean of 1.2%). The maternity service had put in place recommendations to prevent this occurring in the future.

● The Trust told us all incidents of post-partum haemorrhage was reported using their internal reporting system.

● The maternity service lower number of total caesarean section at 26% compared to England’s average of 28%. However; they had higher instrumental deliveries such as use of forceps and Ventouse (suction cup used to deliver a baby) at 14% compared to England’s average of 12%.

● The maternity service had a guideline for sepsis in pregnancy which was revised in April 2018. There was no data currently regarding compliance with sepsis. The Trust told us an audit was planned to start in January 2019 to review antibiotic administration at planned and emergency caesarean birth.

● The maternity service used the National Perinatal Mortality Review Tool in the review of stillbirths and worked with other providers to improve care for women and share learning.

### Competent staff

#### Appraisal rates

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisal required</th>
<th>Appraisal complete</th>
<th>% completion</th>
<th>Met target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified midwives)</td>
<td>268</td>
<td>228</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and midwifery staff</td>
<td>130</td>
<td>95</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>7</td>
<td>5</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>7</td>
<td>5</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified midwives)</td>
<td>50</td>
<td>35</td>
<td>70%</td>
<td>No</td>
</tr>
</tbody>
</table>
At the last inspection we had identified that the Trust was not meeting their staff’s appraisal rate. This had not improved at the time of this inspection. The Trust mandate was for each staff member’s annual appraisal was to include a wellbeing discussion, which helps them to identify any issues at work, or with work life balance, and discuss what support they could provide.

From September 2017 to August 2018, only 79% of staff within maternity care at the Trust received an appraisal compared to a Trust target of 92%.

Staff told us they valued supervision and appraisal of their practices; however not all staff were supported through this process. Senior managers told us they were aware that they were not compliant with this. Opportunities for staff to discuss well-being, work related issues were missed.

Following the inspection, the Trust told us they had taken steps to improve appraisal rates, such as allocating protected times on the duty roster for appraisals.

Midwives at the NFBC told us they had not completed supplementary training for managing the care of women choosing waterbirths. We were told they learned from experience. Staff said band 7 midwives had completed training, however; there were no records kept. This may pose risks to women and babies when using the birthing pools.

A preceptorship programme was available for newly qualified midwives supporting them to gain essential skills and competencies that allowed further development for their roles.

Midwives completed additional training including, human trafficking and asylum seekers, assessing risk, perinatal mental health, domestic violence and female genital mutilation (FGM) identification and referral processes.

Midwives and obstetricians completed multi professional training such as the Practical Obstetric Multi-Professional Training (PROMPT)) which were skills drills training in obstetric emergencies. This is an evidence based training package for responding to obstetric emergencies. This has been associated with improved clinical outcomes and reduced patients’ safety incidents.

The Trust held PROMPT training sessions each lasting an average of 40 minutes. This included shoulder dystocia and post-partum haemorrhage, transfers with cord prolapse/breecb from the community and emergency delivery, maternal collapse, sepsis and anaphylaxis, cartograph and neonatal resuscitation. The aim of this added training was to ensure staff were kept updated with emergency procedures and could respond to women’s needs effectively and safely.

PROMPT data compliance for the last 12 months showed a compliance rate between 90% and 100% for consultant obstetricians, anaesthetists, midwives and maternity support workers. Obstetric trainees including new intake was 51% and trainees excluding new intakes was 88%.

Staff received support through the process of revalidation with their professional body the nursing and midwifery council (NMC).

The Trust told us they had an ‘in-house’ development programme for Band 6 nurses.

The Safer Childbirth guidance recommends that consultants midwives are represented in the workforce at a ratio of 1:500 births. In Southampton there were two Consultant midwives with portfolios of normalising birth, public health, education and research. Southampton has led and participated in the South-Central Consultant Midwifery Trainee programme and development of this role.
Multidisciplinary working

- The maternity services had a well-developed internal multidisciplinary team which included, nursing, medical team, health care support staff, theatre staff, physiotherapist, tissue viability specialists, neo natal team, anaesthetics and community midwives.
- Staff on the wards told us about the “excellent NEST team”. external multidisciplinary working with the NEST teams.
- The triage midwives referred women to the NEST team and there was effective working between all the teams.
- Women records showed staff followed their process and involvement of peri natal mental health midwife, GP and social worker as appropriate to meet women’s needs.
- The records for a woman showed plans were shared with labour line and local maternity units in case the woman presented elsewhere. After birth discharge plans were put in place. Midwife followed up for 15 days and successful handover to health visitor was completed.
- There was evidence of effective communication with GP’s during antennal care/discharge, particularly case studies looked at from the NEST teams.
- Transitional care of babies from neonatal care to postnatal care and involvement of NICU outreach/support were effectively managed.
- The Trust had consultant midwives were available to support women in their choices for their birth experience and to support midwives to deliver this care.

Seven-day services

- The NFBC provided women with 24hr care, seven days a week.
- Women had access to seven-day service and consultant directed care for diagnostic investigations including CT, ultrasound as required.

Health promotion

- Midwives undertook a detailed assessment of women at the initial ante-natal booking visit and supported women throughout the pregnancy as identified. Weight management including high BMI, smoking cessation advice, breastfeeding advice were included.
- Healthy eating and weight management advice was also provided for women both before, during and after pregnancy.
- Influenza and whooping cough vaccines were offered to all pregnant women after 20 weeks gestation and information was available and displayed in the unit
- Women were offered screening for sexually transmitted diseases at the initial assessment during ante-natal appointments. Any positive results were managed by the ante-natal screening midwives for support and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff obtained and described consent to care and treatment in line with legislation.
• Staff understood their roles and responsibilities under the Children’s Act 1989, the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.
• We observed staff gaining verbal consent prior to providing care. Verbal consent was also gained prior to examinations, this was evident in records that we reviewed.
• The midwives we spoke with understood their responsibilities relating to Fraser guidelines and Gillick competencies when caring for a female under the age of 16. The Fraser guidelines refer specifically to consent for sexual health services, and are an additional guideline to the Gillick competency framework that relates to consent for any healthcare intervention.
• Staff told us that issues with capacity was uncommon, however midwives use the Trust guidance and protocols relating to capacity assessment and best interest assessments.

Mental Capacity Act and Deprivation of Liberty training completion

The Trust reported that from September 2017 to August 2018 Mental Capacity Act (MCA) training was completed by 85% of staff in maternity care, achieving the Trust target of 85%.

There was no separate module for deprivation of liberty.

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

Is the service caring?

Compassionate care

Staff treated women with kindness during all interactions we observed.

• Staff were kind and considerate when caring for women. We observed staff providing support to women when caring for their babies in a caring and compassionate way.
• We received positive feedback from women and their partners about their experiences of care they had received in the unit and following their transfer to the NFBC.
• We observed time took time to interact with women in their care and those close to them.
• Women who had opted for home births received help and support if they needed to be transferred to the unit.
• Staff were confident they could and would raise any concerns about inappropriate or disrespectful behaviour towards women and their families.

Friends and Family test performance

Friends and family test performance (ante-natal), University Hospital Southampton NHS Foundation Trust
From May 2017 to May 2018 the Trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

In the most recent month, May 2018, performance for antenatal was 96% compared to the England average of 95%.

Friends and family test performance (birth), University Hospital Southampton NHS Foundation Trust

From May 2017 to May 2018 the Trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.
In the most recent month, May 2018, performance for postnatal wards was 94% compared to the England average of 95%.

**Friends and family test performance (postnatal community), University Hospital Southampton NHS Foundation Trust**

From May 2017 to May 2018 the Trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

In the most recent month, May 2018, performance for postnatal community provision was 98% which was the same as the England average.

(Source: NHS England Friends and Family Test)

**CQC Survey of women’s experiences of maternity services 2017**

The Trust was one of the best performing Trusts for two of the 14 questions and were about the same for the remaining questions in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</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>8.13</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>7.91</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>9.66</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>8.83</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>9.33</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>8.17</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>8.59</td>
<td>About the same</td>
</tr>
</tbody>
</table>
> Thinking about your care during labour and birth, were you spoken to in a way you could understand?
> 9.66
> Best performing trusts

> Thinking about your care during labour and birth, were you involved enough in decisions about your care?
> 8.40
> About the same

> Thinking about your care during labour and birth, were you treated with respect and dignity?
> 9.68
> Best performing Trusts

> Did you have confidence and Trust in the staff caring for you during your labour and birth?
> 9.08
> About the same

<table>
<thead>
<tr>
<th>Care in hospital after the birth</th>
<th>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</th>
<th>7.29</th>
<th>About the same</th>
</tr>
</thead>
<tbody>
<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>7.78</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>8.66</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>8.38</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

- Women and their families were encouraged to complete the maternity friends and family test. Staff had worked to increase the response rate using technology. This had seen the response rate increase from 21% in August 2018 to 50% in November 2018. The increase response rate has seen a slight reduction in positive comments however 88.6% of women would recommend the maternity services to others.

**Emotional support**

*Staff supported women to cope emotionally with their pregnancy, birth, postnatal care and treatment.*

- There were arrangements in place to support women and their families following bereavements and women had access to specialist bereavement team leads.
- The maternity service had a specialist midwife who offered bereavement support. The service worked closely with SANDS (still birth and neonatal death charity) who provided the unit with memory boxes.
- Women were asked about their emotional well-being at ante-natal and post-natal visits and received support from the specialist teams as needed.
- Women were monitored and had access to mental health support. There were two family care advisors who offered a counselling service for parents whose babies were in the neonatal unit.
- Clinical Midwife specialists were available to advise and support women and staff.
The care records contained assessments for anxiety and depression and staff explained risks and benefits of different options of care and recorded the decisions in women’s records.

Understanding and involvement of patients and those close to them
Staff involved women and those close to them in making decisions about their care.

- Staff encouraged women and their family members to be partners in their care and in making decisions. We observed staff spending time talking to women and those close to them.
- Women were given the opportunity to choose where they had their babies to meet their needs. Any clinical risks were explained as part of the decision-making process and they were supported. The women we spoke with told us they had felt fully involved in their care. Staff shared information with them and women were encouraged to ask questions in order to make an informed choice.
- Women attending the clinics told us they needed blood tests for gestational diabetes and were fully informed about the process.

Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy

From October 2017 to March 2018 the bed occupancy levels for maternity were generally lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.
(Source: NHS England)

Number of clinical transfers of women and babies from New Forest Birth Centre

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfers from NFBC</td>
<td>4</td>
<td>11</td>
<td>9</td>
<td>7</td>
<td>12</td>
<td>8</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>PPH⁴/suturing/BP⁵/etc</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PN⁶ transfers for baby</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Transferred in 1st or 2nd stage</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Transferred in 3rd stage</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

- The New Forest Birth Centre (NFBC) is a midwife-led unit and accommodated women who were assessed at the antenatal stage as low-risk. Women we spoke with confirmed that they were aware that they may need to be transferred to the main hospital site at Princess Anne Hospital if they developed any complications.
- Data we received from the Trust showed that a proportion of women admitted to NFBC were transferred to the Labour Ward. These were clinical transfers; the most common type of transfers was delay during the first or second stage of labour. One woman had post-partum haemorrhage (excessive blood lost following birth), two women required suturing and three were post-natal transfers.

Meeting people’s individual needs

- Midwives identified women with mental health needs through the antenatal screening clinics. They referred those with moderate to severe mental illness to specialist perinatal mental health teams in the community or to a local mother and baby unit. There were clear guidelines for referral mental health support and access to the learning disability teams.
- Working closely with the neonatal unit the Trust provided accommodation for out of area women and their families whose babies were being cared for in the neonatal unit so parents could remain close to them.
- The Trust had set up a needing extra support midwife team (NEST) who worked with women with complex needs and their families and provided support to those with mental ill health, substance misuse or homelessness.

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⁴ Post-partum Haemorrhage  
⁵ Blood pressure  
⁶ Postnatal
The midwives assertively outreach the women in the community and encouraged the women to engage. The midwives have a caseload of women and saw this through to birth and follow-up for 15 days.

Staff had access to translation services available for women whose first language was not English. Staff confirmed this could be accessed out of hours.

We saw a case study which supported a woman with learning disability and mental health issues. Consultant midwives supported the midwives and women in advocating for non-intervention and normalising births when indicated.

There were arrangements to support women expecting multiple births. The maternity service had clear guidelines for multiple births. This included guidance through the whole pathway from antenatal labour and post-partum care.

Access and flow

The Trust planned and provided services in liaison with the wider health economy to meet the needs of local women.

- The Trust reported there were 5626 births in 2017 across the maternity services which was slightly down from 5749 in 2016. The Trust data indicated that demand has remained stable on the service with a similar volume of deliveries over the past two years, although there were fewer births in 2018.
- The Trust believed they have improved upon the previous inspection with potentially improvements to patient safety however it was unclear if there was specific data to support this.
- There was no waiting list for women to access needing extra support team (NEST) or safeguarding midwife teams.
- All referrals were triaged by midwives before allocation to NEST team. A NEST midwife commented “We offer complete continuity for our families.”
- There was an internal procedure that staff followed for women who missed their appointments, they were initially rebooked and followed up as home visit by community midwives.
- Women had access to the labour line, midwives triaged women and offered support and advice which included early labour. One woman told us they had used this service which meant they helped them decide when to attend the unit and said the staff were helpful and provided reassurance.

Learning from complaints and concerns

Summary of complaints

From September 2017 to August 2018 there were 26 complaints about maternity. The Trust took an average of 51 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 35 working days.

The top three subjects of complaint were ‘Attitude of nursing staff/midwives’ (four), ‘Communication with the patient’ (four), and ‘Mismanagement of labour’ (three).
Number of compliments made to the Trust

From September 2017 to August 2018 there were four compliments within maternity.

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

- Between April 2018 to November 2018, there were 17 complaints and complex concerns. Eight complaints were partially upheld, two complaints were not upheld, six complaints were closed and one complaint was still open.
- The Trust told us that in the period between October 2018- January 2019. There was no case outside their target.
- Information on how to raise concerns or complaints were available to patients. The maternity services circulated a monthly “Experience of care” divisional performance report presented as a dashboard. This also included positive experiences of care.
- Staff knew how to handle complaints. Staff told us they tried to deal informally with concerns and to do this promptly to provide a timely resolution to concerns. Informal complaints were logged and tracked as well as formal complaints.
- Patients could raise their complaints through Patient Advice and Liaison Service (PALS) and formal were shared with maternity leads.
- The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared with staff. These were not completed in a timely way; detailed responses had resulted in delays for the complainants which the Trust was working to improve.
- The trust told us that women and their families were encouraged to raise concerns through both the ‘Now is the Time to Ask’ poster and through the ‘Safety Champions’ poster.

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.

- We found that the maternity teams were a cohesive team and had senior midwives in position. The managers were visible within the service during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support and leadership. All staff we spoke with, commented positively on this.
- The team leads had the skills, knowledge and experience to perform their role. They demonstrated a comprehensive understanding of the services they managed. All the managers we interviewed had been offered leadership development opportunities, such as coaching skills and managing a budget.
- Most staff knew who the senior managers and executive directors were. They had met the chief executive and executive and non-executive directors. Staff said they had raised issues
with senior managers and felt they had been heard and action had been taken. All staff said they could raise issues with their manager if required and action would be taken.

- Managers encouraged and supported innovation, for example, the development of the midwife led pathway and the obstetric led pathway.
- The Trust had employed two consultant midwives to support the other staff.
- Managers ensured midwives and obstetric staff developed safety practices when involved in the performance of invasive procedures, as set out in the national standards for Invasive Procedures (NatSSIPS). These national standards covered all invasive procedures including those performed outside of the operating theatre.

**Vision and strategy**

**The Trust had a vision of putting patient first, working together and always improving.**

- The vision for the maternity service was aligned to ‘Better Births’, the report of the National Maternity Review, published by NHS England in 2016 and the Maternity Transformation Programme.
- 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;
  - They were working in increasing the proportion of women choosing to give birth in midwifery led units or home births and supporting women to make informed choices.
  - They were working on creating a single maternity electronic patient record for all women and babies. Improving outcomes for women and babies and to include a decrease in infant mortality.
- The Trust’s vision and values were on display in all areas. Staff understood the Trust’s vision and values and how these were applied in the work of their teams. The Trust’s senior leadership team had successfully communicated this to front line staff through regular updates, bulletins and clear communication processes.
- All midwives commented positively about the Trust and said they fully upheld the vision and strategy of both maternity services and the Trust. “We put women first, work superbly well as a team and strive for improvements” (midwife). “We feel very much a part of this organisation” (midwife)

The Trust staff strategy plan 2018 was to have excellent core Human Resources services to ensure speed, simplicity and fairness, whilst maximising opportunities for productivity and flexible responsiveness.

**Culture**

- The staff respected patients’ diversity and human rights and staff had received training on equality and diversity. Attempts were made to meet people’s individual needs including cultural, language and religious needs.
- The staff we spoke with which included midwives, support staff and obstetricians described their culture as being supportive and approachable colleagues. They described the team as an inclusive and supportive. The staff we met told us they felt cared for, respected and listened to by their peers and managers. The Trust scores for staff formally reporting
incidents of harassment, bullying or abuse had improved since the 2015 results (43% in 2016 from 37% in 2015). The Trust remained below average compared to other acute Trusts in these areas (45%).

- Senior managers told us that they recognised that these were areas where the needed to improve. The trust was on a trajectory of sustained action over a longer period in order to make the required cultural and behavioural improvements they wished to achieve. The action plans into 2017/18 was to continue to focus on the areas of greatest concern for their staff.

- The data highlighted that the experiences and opportunities for BME staff were less favourable compared to white staff. The trust reported there had been marginal positive improvements year on year, the pace was slow and there was still a considerable way to go before the Trust truly achieved race equality.

- The highest levels of discrimination were reported by their BME staff (26%), those from disabled staff (16%) and by men (14%). (UHS Staff Survey Result 2016).

- The trust was aware of the need to develop the equality and diversity further in the trusts day to day work and for supporting opportunities for career progression. The trust was working on feedback from the staff survey where some staff groups felt they were not treated as equals.

- The trust had developed their Freedom to Speak Up (FTSU) guardian initiative. The Trust had received 25 cases since the appointment of the FTSU guardian in October 2017. The Trust received 13 FTSU cases from April to September 2018.

- The Trust hosted a regional FTSU meeting on the 13th November 2018 with representation from the National Guardian.

- The NHS Improvement/FTSU office self-review tool undertaken by the Trust was discussed at the Trust board study session in July 2018. The review identified some action points which included:
  1) Develop a FTSU vision and strategy
  2) Communicate the FTSU message
  3) Establish a network of FTSU Champions
  4) Share lessons learnt

A summary of all cases received since the appointment of the FTSU Guardian (October 2017) is detailed below-

<table>
<thead>
<tr>
<th>Category</th>
<th>2017/18 Q3</th>
<th>2017/18 Q4</th>
<th>2018/19 Q1</th>
<th>2018/19 Q2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breach of Confidentiality</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Bullying and Harassment</td>
<td>5</td>
<td>4</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Concern over HR process</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Discrimination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety Issue</td>
<td>2</td>
<td></td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Policy Implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Recruitment</td>
<td>2</td>
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<td></td>
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<tr>
<td>Team Dynamics</td>
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<td></td>
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<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>7</strong></td>
<td><strong>7</strong></td>
<td><strong>6</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>
Governance

- The midwifery leadership structure comprised of director of midwifery with the senior midwifery manager, midwifery matron and midwifery quality assurance manager reporting to them.
- There were governance and assurance meeting, performance meetings, divisional governance and assurance meeting and divisional management executive meeting 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.
- The midwifery quality assurance manager monitored and reported to the maternity governance committee and the clinical effectiveness committee. This information was reported to the head of clinical governance.
- Mandated training for maternity staff were formally approved through Women and Newborn Governance Steering Group.
- There was a monthly MQUEST meeting (Maternity, Quality, Education and Safer Together) which has replaced the Perinatal Morbidity and Mortality meetings. An MQUEST messenger is produced following the meeting which is circulated via email to all maternity staff and is displayed in some areas.
- Staff we spoke with said they raised any quality issues to their managers who reported them to the Matron to escalate at the senior leadership meetings to be discussed.
- There were regular staff meetings and newsletters for sharing information and updates which were cascaded up and down through the service. There were regular agendas or risk meetings and the minutes were distributed.
- Senior midwife representatives and the divisional governance manager attended the Trust monthly quality governance steering group.
- Senior midwives had access to their team’s performance dash boards so could monitor their team’s key performance indicators and key risk issues.
- The maternity teams used the boards daily in handover and clinical meetings. The electronic system triggered risk incidents, for example, excessive blood loss, eclampsia, hysterectomy, deep vein thrombosis and any fatality.
- The Trust had initiated a leadership development programme be shaped around their vision and values to deliver resilient, compassionate, forward-thinking and capable leaders needed for the future.

Management of risk, issues and performance

The maternity service had systems in place for identifying risks, planning to reduce them.

- The maternity service had one risk register which incorporated the antenatal, post-natal and delivery suites. The risk register was reviewed monthly by the care group manager and risk lead and on a quarterly basis at the Maternity, Neonatal and Women’s Services Governance Groups.
- The service had signed up to several work streams to review maternal deaths, stillbirths and infant deaths that included:
  - Each Baby Counts – Royal College of Obstetricians and Gynaecologists national quality improvement programme to reduce the number of babies who die or are left severely disabled because of incidents occurring during term labour. This worked alongside NHS Resolutions’ early notification scheme.
  - Saving Babes Lives – designed to tackle stillbirth and early neonatal death.
Sign up to Safety – a national campaign to help make the NHS the safest healthcare system in the world.

- The safety maternity care report 2016 called on maternity services to designate and empower three individuals to champion maternity safety in Trusts. The Trust had implemented this initiative with the Director of Nursing providing board level leadership.
- Information was available and key messages related to quality and risk. Changes were shared by email, lessons of the month, and there was a monthly presentation of the top risks in the service on the midwifery study days.
- Potentially serious or high-risk incidents were scoped within 72 hours and reviewed by the quality and risk manager, clinical service lead and head of midwifery and any immediate actions taken as required.
- The trust told us the maternity service has undertaken a staff Safety Culture Survey in 2018 to establish the culture within the maternity service teams. This would help the Trust in identifying team cultures and provide resources to support safe care.
- The trust had told us that they had a ‘Safety Improvement Plan’ in place to support the drive to improve quality, reduce risk and to improve outcomes for women and babies.
- The Trust told us the maternity service ‘Maternity Safety Champions’ in place at both maternity and executive level who meet monthly to discuss current and on-going safety issues within the service.
- The Trust said they had developed their social media service in the last year where they shared information with women.

Information management

- The risk register had identified that risks of under reporting of incidents due to the lack of availability of IT remote access. It also showed that IT provision and support was not currently provided for the community localities and there was no ability for printing information. The risks were that information may not be available to staff and staff had to travel to the main hospital site to record incidents.
- The Maternity Service currently had a record system called Hospital Integrated Clinical Support System (HICSS) where important pregnancy information was recorded. Within HICSS there was a requirement for the midwife to record if a FGM had been disclosed and the type of involvement necessary. This information was captured at booking and at birth.
- The trust told us they had told us there were staff available to support the midwives in the community to access women’s records. The Trust had recognised IT connectivity could be an issue in the community and said staff travelled to the hubs to access records.
- The national trajectory is for 20% of women to be booked onto a pathway that provides continuity of care by 2019.
- The Trust is part of the Local Maternity System (LMS) responsible to deliver on the recommendations of current national maternity strategy.
- The maternity unit at Southampton together with Hampshire, Isle of Wight and Portsmouth (SHIP) had developed a shared vision and Local Maternity Transformation Plan and proposed to deliver these recommendations by 2020/2021.
- Reduce the rates of stillbirth, neonatal death; maternal death and brain injury during birth by 20% by 2020 and are on track to make a 50% reduction by 2025. The Trust was investigating and learning from incidents and sharing this learning through their Local Maternity System and with others.
The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and measures against national outcomes.

The trust had told us that they had recognised the potential risk of IT connectivity issues. They had put systems in place such as admin support, staff would access the birthing centres and Hubs. There were ‘community co-ordinators’ at the other sites who could obtain information for the staff.

The maternity dashboard included service performance measures which managers reported on to the board. The maternity dashboard contained information relating to activities such as the number of planned and emergency caesarean sections, perinatal mortality, post-partum haemorrhage and the number of emergency admissions to the service.

### Public engagement

- Women and their families were encouraged to complete regular surveys to provide feedback on the care they had received. Themes of concerns and complaints and feedback from the ‘friends and family test’ survey was reviewed regularly.

- The maternity service participated in a domestic violence awareness week. The specialist midwife sat on the multi-agency domestic violence forum with police, probation, women’s aid, and victim support. A newsletter was prepared by this forum and circulated monthly.

- Staff worked with local people and the council to create a “breastfeeding friendly” city. Also contributed to world breastfeeding day in conjunction with health visitors and the NCT.

- The maternity unit ran a birth “after thoughts” initiative which invited mothers to come back to the maternity unit at any time after the birth of their baby to discuss their experience. Each mother was given a bookmark with contact details for the unit. Women could ask questions, provide meaningful feedback or raise any concerns.

- The friend and family test results showed that 93% of women would recommend the service to family and friends. 95% would recommend the labour ward and birthing units, 88% the post-natal wards and 83% would recommend the community service to friends and their families.

### Staff engagement

- The staff strategy plan 2018 for the Trust and their three main values of patients first, working together and always improving. culture has been internally and externally recognised as being positive, but need to go further in order to fully maximise our potential.

- The 2017 staff survey results showed 86% of UHS staff said patient care was the top priority and 76% would recommend UHS as a place to work. Also 57% of staff said they had enough equipment to carry their jobs and 33% of staff said there were enough staff to meet the needs of patients. The Trust had developed an action plan in response to the staff results and there were other workstreams in progress such as work “after thoughts” sessions for staff to make suggestions for improvements and mindfulness sessions for staff.

- Theme of the week was circulated to all staff highlighting lessons learnt either from an accident or complaint. The unit had communication folders which were available updating
staff on a variety of topics. The trust told us that regular ‘themes of the week’ posters were used to raise awareness and promote safety culture.

- Daily meeting occurred on Labour ward to discuss any cardiotocography issues and opportunity for debriefing for staff.

Learning, continuous improvement and innovation

- Staff contributed to the on-going development of services and implementations of new ways of working. Staff were confident in explaining how they delivered high quality care, support and treatment within a defined budget.
- Quality improvement projects included action plans to address the five national safety priorities which were: Improve smoking cessation rates (dedicated specialist smoking cessation midwife), management of neo natal hypo glycaemia, recognising any deterioration of mother and baby, stabilisation of the pre-term baby and stabilising diabetes in mothers.
- The Trust had developed the home birth team in October 2018 for all low risk women.
- Another quality improvement project was set up looking at improving the early recognition and management of deterioration of either mother or baby during labour. Also, empowering women and staff to speak up and ask questions and improving the stabilisation of preterm babies.
- The research midwives were carrying out a randomised controlled trial comparing two different types of sutures.
- Another trial of a pessary looking at the prevention of per-term birth in twin pregnancy and working to understand how nutrients were transported across the placenta.
- Women were encouraged to collect colostrum pre-birth.
- The national apprenticeships agenda, coupled with new frameworks for the training of healthcare professionals, provided the Trust with a platform to deliver education in partnership with new and emerging education providers who are entering the market. Traditional direct entry via degree based healthcare education will remain an important entry point into the NHS.
Southampton General Hospital

Evidence appendix

Date of inspection visit:
4 December to 24 January 2019

Date of publication:
17 April 2019

Acute services

Urgent and emergency care (Southampton General Hospital)

Facts and data about this service

The trust provides urgent and emergency services to adults and children in and around the Southampton area. The trust attained accreditation as a designated major trauma centre in 2012. Major trauma centres are specialist unit established to provide specialised trauma care and rehabilitation. Both adults and children suffering major trauma from across Southampton, Hampshire, the Isle of Wight, Portsmouth and surrounding areas are transferred and treated at Southampton General Hospital.

The emergency department is located at Southampton General Hospital; the adult majors and minor injury unit was opened in 2000 and comprises a minor injuries area, 20 major’s bays, of which one is designated as a “Fit to Sit” seating area and a six-bedded dual use resuscitation bay.

The children’s purpose built emergency department is audio-visually separated from the main adult emergency department and was opened in December 2018. The children’s emergency department treats approximately 22,000 children per year.

There are separate waiting facilities for children and young people. The department operates two single-sex clinical decision units and a transitional care unit. X-ray facilities are co-located within the department.

As part of the inspection we spoke with 19 patients, two parents of children receiving care, thirty-five members of staff including, nurses, doctors, consultants, managers and support staff. We also reviewed 15 patient care records and observed clinical handovers, bed meetings and daily safety huddles. We attended a weekly emergency department meeting which was chaired by the Chief
Executive and considered the development and performance improvement plans for the emergency care pathway.

We inspected the service between 22 and 24 January 2019. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

We last inspected urgent and emergency services in December 2015. As a result of that inspection, we rated urgent and emergency services as requires improvement.

Details of emergency departments and other urgent and emergency care services

- Southampton General Hospital

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

Activity and patient throughput

Total number of urgent and emergency care attendances at University Hospital Southampton NHS Foundation Trust compared to all acute trusts in England, July 2017 to June 2018

From July 2017 to June 2018 there were 149,478 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(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 decreased in most 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from July 2017 to June 2018

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

(Source: Hospital Episode Statistics)

Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or
discriminatory abuse.

Mandatory Training

Mandatory training completion rates

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

Trust level

A breakdown of compliance for mandatory training courses from September 2017 to September 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Incident Planning</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>149</td>
<td>152</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>148</td>
<td>152</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>145</td>
<td>152</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>141</td>
<td>152</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>140</td>
<td>152</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>133</td>
<td>152</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>132</td>
<td>152</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>127</td>
<td>152</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>123</td>
<td>152</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 85% target was met for eight of the ten mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>66</td>
<td>67</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>64</td>
<td>67</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>56</td>
<td>67</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>50</td>
<td>67</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>50</td>
<td>67</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>49</td>
<td>67</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>38</td>
<td>67</td>
<td>57%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>------------------</td>
<td>----</td>
<td>----</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>37</td>
<td>67</td>
<td>55%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>20</td>
<td>64</td>
<td>31%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 85% target was met for two of the nine mandatory training modules for which medical staff were eligible.

The tables above include staff that work across both Southampton General and Lymington New Forest Hospital.

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

The management team acknowledged that compliance against mandatory and statutory training required improvement. Since the submission of the initial dataset within the provider information request, the service was able to demonstrate improvements across a range of modules including health and safety awareness (91.4%), infection prevention and control (80.6%), local induction (86%), adult life support (78.7%) and moving and handling (61.3%). Local initiatives were in place to encourage and support more staff to complete their mandatory training. These included ensuring a dedicated computer was available for staff to use during periods of low patient activity. Staff were also allocated protected time to enable them to complete mandatory training. The trust also reported the following initiatives:

- Monthly face to face mandatory training mornings available to all staff.
- Regular bespoke training sessions for cohorts of specified staff groups such as mandatory training mornings for non-registered nursing staff focussed on their role and learning needs to support quality and safety.
- One off bespoke training sessions for selected staff groups such as a planned session in February 2019 for moving & handling for registrars and a planned session in March 2019 covering basic life support for non-clinical staff.
- Training is also provided on an individualised basis where required, for example aseptic non-touch technique (ANTT) is provided by three members of staff within the department who have undergone ‘train the trainer’ training.

(Source WL-057 – Current Mandatory Training figures)
Safeguarding

Staff were aware of their roles and responsibilities regarding safeguarding both adults and children.

We reviewed five sets of notes specifically relating to the care of children. In each case, staff considered the history provided by parents to consider whether the presenting injury was appropriately explained. Care records included “Red flag” concerns which were completed in each case. Red flag concerns prompted staff to consider subtle safeguarding concerns and to explore
any specific areas of concern including domestic violence, multiple hospital or health-professional contacts as well as those at risk of neglect.

When staff had concerns about a vulnerable adult or child they made referrals to the trust safeguarding team or the local authority. Flow charts for this process were visible in the department. Staff we spoke with were familiar with these and provided examples of the issues they should refer.

The department had an established vulnerable adult support team (VAST) which was recognised nationally for its innovate approach. VAST was a dedicated team of 5.4 whole time equivalent health professionals, managed by a nurse consultant who was also the lead for safeguarding adults and mental health in the emergency department. VAST was available in the emergency department seven days a week. The team was made up of support workers who identify, thoroughly assess and signpost patients with any level of assessed vulnerability including but not limited to mental health concerns, domestic abuse, sexual exploitation, alcohol and substance misuse, homelessness and those at risk of radicalisation, forced marriage or female genital mutilation. The team also identified those individuals with learning disabilities. The team were highly valued by the wider emergency department team. VAST members were highly knowledgeable about all available community supports initiatives and spent nine days on induction visiting these community groups and making links. The team carried out joint assessments with, for example, psychiatric liaison.

An up to date safeguarding policy covered all aspects of safeguarding including female genital mutilation and child sexual exploitation. Staff showed us the process for accessing policies on the trust intranet. Guidelines and information were available to support staff to recognise and manage cases of suspected domestic violence or sexual assaults. Patient information was available across the department including information relating to domestic violence being placed in the public toilets.

Human trafficking is an issue that is rarely encountered in ED, however, staff wanted to provide safe and robust interventions. The VAST team have access to a briefing paper and PowerPoint presentation (which has previously been delivered to them) about human trafficking. These were derived from national guidelines. Members of VAST had provided briefings on the topic to all members of the ED team.

Staff in ED had written a draft policy about responding to concerns about forced marriage. At the time of the inspection the policy was out for consultation at a trust level, but was already available to the VAST practitioners and ED team as an interim measure. Like human trafficking, staff acknowledged this was an issue staff in ED encountered infrequently, however the department had written an information checklist and briefing for staff, to ensure comprehensive interventions were given.

Within the Southampton area there existed an alliance of community domestic abuse and sexual violence services which worked under the umbrella name of “Pippa”. The Pippa helpline for professionals was set up at around the same time as VAST (in 2012) and received referrals for victims of domestic abuse. VAST practitioners referred into the High Risk Domestic Abuse (HRDA) mechanism which sits alongside the Multi Agency Safeguarding Hub (MASH). The ED consultant nurse was on the multi-agency working group for this change. It provides a much timelier response to high risk domestic abuse referrals and avoids duplication of work (with MASH) when there are
children in the family. For ‘below high risk’ referrals, the team refer to Pippa. Referrals were always made to MASH as well if a ‘below high risk’ victim had children.

Staff reported a domestic abuse intervention would typically take 1-2 hours and longer if staff were seeking a refuge space for patients and their families. ED staff reported they could not effectively commit the time to undertake such referrals and so welcomed the support of the VAST team.

The trust had access to high-level information relating to children who may be subject to a child protection plan or who were categorised as a “vulnerable” or “at risk” child. Flags appeared against any patient on the electronic dashboard which acted as a trigger for staff to consider whether a patient was known to be vulnerable by way of medical or social history.

Staff had a good understanding of the national “Think Child” campaign, and could provide examples of when a child may be vulnerable. Further, staff could describe examples of what may constitute a vulnerable person including those at risk of neglect, financial abuse, child sexual exploitation, female genital mutilation, domestic violence and abuse.

Health professionals such as a band seven member of the paediatric liaison team reviewed the care records for all children who attended the emergency department. There were protocols in place for referring relevant children to local authorities, especially in the case of children already known to social services or those children recognised as being a vulnerable child. This process acted as a safety net and ensured any potentially vulnerable child or young person was identified and appropriate referrals or action taken where necessary to safeguard individuals. Health visitors were informed of any children under the age of five who attended the department. School nurses were notified of children aged five and above who attended the emergency department. This ensured children and families could be supported once the child had been discharged home.

**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 September 2017 to September 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>22</td>
<td>22</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>130</td>
<td>152</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>15</td>
<td>21</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 85% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.
A breakdown of compliance for safeguarding training courses from September 2017 to September 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>33</td>
<td>33</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>52</td>
<td>67</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 85% target was met for two of the three 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 risks associated with infections well. Staff protected themselves and patients from the risk of infection by adopting good hand hygiene and utilising personal protective equipment in the majority of cases. However, some equipment and areas of the emergency department were found to be dusty or unclean.

During our previous inspection we found that whilst the department was visibly clean and tidy, staff did not always adopt best practice in regard to hand hygiene and the use of personal protective equipment. We undertook an unannounced inspection of the emergency department and found compliance had improved. During this recent inspection, staff working in the majors and resuscitation areas were observed consistently following the five steps of hand hygiene, adopted personal protective equipment where necessary and adopted isolation protocols for patients who could have possible been infectious. Nurses working in the triage rooms were observed making direct patient contact to enable them to undertake physical observations of patients; the frequency with which nurses decontaminated their hands between patient contacts was sporadic.

Some areas and equipment we inspected including corridors, waiting areas, patient bays, toilets and trolleys were found to be dusty. Other areas of the department were visibly clean and tidy. Senior nursing staff undertook monthly “Fifteen steps Challenge” audits. These audits included a walkthrough of different sections of the emergency department and considered a range of parameters for assessment including whether the department was clean and well maintained, that waste and linen had been disposed of appropriately, that commodes were clean and that infection prevention and control information was available. We reviewed the audit results of seven “Fifteen Steps” audits for areas including majors, clinical decision unit, resuscitation area and minors. Staff identified minor areas for improvement but no areas which required immediate action or remedial action.

Cleaning schedules were displayed throughout the department which were completed to demonstrate clinical areas had been cleaned regularly. However, our observations of the department suggested the extent and effectiveness of cleaning required review. We noted one toilet (door reference EC119B) which was located near to the Pit-stop assessment area had no cleaning regime. The bin located in the toilet was overflowing, the ceiling call bell cord had been removed as this had posed as a ligature risk and urine was noted on the floor. One mobile ultrasound scanner and a suction unit were noted to be dusty. Due to the age of the department,
some walls had sustained damage resulting in the protective layers being removed, therefore imped-ing the ability to effectively decontaminate surfaces. A number of curtains throughout the department had no dates recorded for when they had last been changed.

Domestic staff used colour coded bags to segregate infected linen from clinical waste, and colour coded mops were used in the same way. Deep cleaning was undertaken based on a schedule which the trust managed centrally.

Sharps disposable bins were located throughout the department. The bins were replaced on a regular basis by an external contractor. Lids were noted to be closed and no bins were found to be overflowing, therefore reducing the risk of needle-stick injuries to staff.

There were no reported cases of methicillin-resistant *Staphylococcus aureus* infections associated with care and treatment provided in the ED during the reporting period of April to September 2019 *(Source: WL062)*.

There was one reported case of *Clostridium difficile* infections associated with care and treatment provided in the ED during the reporting period of April to September 2019 *(Source: WL062)*.

**Environment and equipment**

The service had suitable equipment and looked after them well. The department was dated and was no longer of a sufficient size to meet the increasing demand of the local population.

Resuscitation equipment was routinely checked to ensure it was ready for use. We reviewed records which confirmed checks occurred daily.

Theoretically, the six-bedded resuscitation bay was reported to be of an appropriate size for the expected activity of the hospital. However, staff reported that during times of surge and poor hospital flow, patients would remain in the resuscitation bays for longer than was necessary; this impacted on the effectiveness of the department as majors’ cubicles were then required to manage new patients who required resuscitation. The lack of resuscitation capacity had been noted on the departmental risk register. Staff were observed to be managing the resuscitation area dynamically. Patients were individually risk assessed when additional resuscitation capacity was required. Doctors and nurses reviewed individual patients to determine whether individuals could be safely managed in the major’s area whilst a bed in the correct care setting could be secured for patients. The department lacked any high dependency or step-down bed spaces but had considered these would be of immense usefulness during periods of surge.

During routine activity, each resuscitation bed space was separated by specialist walls which meant patients were not over-exposed to radiation when patients in neighbouring bays received mobile x-rays. Two resuscitation bed spaces were equipped to manage both children and adults; we observed these bays being used appropriately.

The department had developed a plan to relocate the resuscitation department; these works were scheduled to commence later in 2019.

We previously reported the emergency department to be small and cramped which resulted in patients being nursed on trolleys in the corridor. At this recent inspection, a new children’s emergency department had recently opened and plans had been developed to enable a small expansion and redesign of the department to help improve patient flow. However, the department remained cramped with a disjointed footprint split across three corridors. The major’s department had twenty bays; one bay had been reconfigured as a “Fit-to-sit” area enabling faster treatment of
...sub-acute patients. At peak times, this area was noted to be cramped, especially when patients required additional monitoring or were receiving medication via infusion pumps or syringe drivers; the design and configuration of the area also did not lend itself to protecting patients from the risk of cross-infection due to the proximity of chairs.

Majors bed spaces 10-17 had been split thus creating additional major’s capacity in the department. Each of these bed spaces were small and allowed only enough space for a trolley. We noted there was not sufficient space within these bed spaces to enable an effective resuscitation event. Staff recognised this and mitigated against such risks by ensuring only low acuity patients were nursed in those spaces. Nurses and doctors had good line of sight of the bed spaces from the central staffing station located in the centre of the major’s department.

The layout of the main waiting area meant clinical staff had limited line-of-sight of patients who self-presented to the emergency department. We raised this with the trust at the time of the inspection. The trust responded proactively by increasing the clinical oversight of the waiting room with the introduction of a nurse to monitor the waiting area during peak times.

Consumable equipment was of sufficient supply, was in-date, and stored off the floor. Chemicals for cleaning (or other substances hazardous to health) were stored in locked cabinets in locked rooms.

Medical equipment including syringe drivers, infusion pumps and patient monitoring equipment had all been serviced and tested for electrical safety.

The department had recently opened an enhanced care suite (ECS). The suite contained mental health assessment rooms which were safe for both patients and staff. The suite was self-contained, within the ED and had two spacious rooms, a toilet and shower facility, a nursing station and a clinical room. Anti-ligature fixtures and fittings were used throughout and there were no ligature anchor points. A ligature risk task and finish group had planned for and overseen the development of the room. Windows were made of toughened glass, a strip emergency alarm was available around all walls, CCTV was used to mitigate any blind spots in the two rooms, doors were all anti-barricade, furniture was weighted (to prevent being thrown) and privacy shutters and frosted windows were in place throughout. The ECS was completely self-enclosed so privacy and dignity was protected for those using the area. The area was secure, quiet and discreet.

Assessing and responding to patient risk

The service effectively assessed the risk to patients and acted where appropriate.

Patients who self-presented to the department were booked in by a receptionist. Once booked, the four-hour target time started, in line with the Department of Health’s standard for emergency departments that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

Patients who attended at the front door were assessed by a nurse and streamed to the most appropriate area. A brief history and basic observations including calculation of early warning scores were taken by the assessment nurse. Patients were assessed by a nurse and then streamed to Pit-stop; minor injuries; majors or resuscitation room. Children who presented to the department were directed to a children’s only waiting area which was audio-Visually separated from the adult waiting room. A children’s nurse was allocated to oversee the children’s waiting area and to also undertake the initial assessment of children. The department followed guidelines for the streaming of patients to the children’s early emergency department, paediatric assessment
unit or the resuscitation bay to ensure they were sent to the correct area of the department which best met their needs.

Nationally developed patient safety systems helped staff to assess, prioritise and monitor patients. These included baseline clinical observations, a nationally used triage system and an early warning score (NEWS2) system.

Triage systems aim to reduce risk by triaging patients and seeing them in order of clinical priority, rather than order of attendance.

The EWS system uses clinical observations to produce an overall score to indicate how unwell a patient may be. To accurately calculate an EWS, a range of clinical observations should be completed. If some observations are not completed, the score may be inaccurate. Early warning scores were available for children and adults and helped staff identify deterioration. Whilst patient record charts for adults did not have colour coded areas as are often seen on early warning charts, staff were conversant with the clinical parameters. Clear guidance was printed on the patient records as were reminders of clinical parameters, including normal and abnormal ranges. Clinical escalation protocols were available in the department. We observed staff escalating care as required during the inspection to medical staff. Patients with high early warning scores were monitored by the nurse-in-charge and the consultant-in-charge.

The department had recently introduced a comprehensive care bundle which was observed to be consistently used. The care bundle prompted staff to complete rapid assessments across a range of health measures including physical observations, falls risks and skin integrity, sepsis screening, peripheral cannula insertion records and visual infusion phlebitis management. Staff also consistently used hourly safety checklists which prompted staff to consider pain management, vital signs, level of consciousness, nutrition and hydration needs and speciality referrals for those who were identified as being vulnerable for example.

We looked at a sample of observation charts in the ED. They were consistently completed, showing that observations were taking place with the required frequency.

Risk assessments were used to record and act on patients at risk of reduced skin integrity, falls, venous thromboembolism (blood clots), safeguarding vulnerability or delirium (confusion).

There was a well-developed ED protocol for managing violence and aggression. The consultant nurse for emergency care (vulnerable adults), had recently assessed the department against the NICE guidelines for violence and aggression and was finalising an action plan. The ED trialled a series of training days on conflict resolution and breakaway techniques. These were very popular with staff and ED have proposed that this is rolled out to all permanent ED staff. The new programme included 3 hours of conflict resolution; 1.5 hrs de-escalation for patients with mental health needs and/or cognitive impairment and 3 hrs breakaway techniques.

The ED staff were currently undertaking a project to clarify options for managing extreme violence from patients with mental health needs. The trust’s head of security, head of health & safety and the consultant nurse were all members of the trust violence and aggression group which met monthly and was chaired by the Deputy Director of Operations.

Patients presenting in ED with mental health issues were assessed using a recognised mental health risk assessment. This graded the risk of self-harm or harm to others as red, amber or
green. We reviewed five patient records and found the risk assessment was used consistently and fully. There were good working relationships with the on-site psychiatry team who responded in a timely way for any patients requiring a formal mental health assessment.

Staff were familiar with the major incident process which enabled them to coordinate and manage large scale or very serious incidents in line with good practice. We reviewed the major incident plan which was up to date and contained relevant information such as instructions when responding to chemical incidents or dealing with terrorism concerns.

A range of clinical pathways existed which ensured patients presenting with specific conditions could expect to receive standardised care and treatment aligned to best practice recommendations. Junior medical and nursing staff could describe the process for the management of sepsis, including the use of a ‘Sepsis 6’ assessment tool. A review of clinical notes confirmed staff routinely used the sepsis 6 care bundle. Clinical guidelines supported staff in managing sepsis; the trust antibiotic guideline, accessible from the trust intranet, included guidance for the management of sepsis of an unknown origin for example.

We observed rapid attendance of clinical specialities to the emergency department when pre-alert calls were received from the ambulance service. Members of the stroke team responded to all stroke calls, even if medical history suggested the patient was outside the optimal window for thrombolysis. Members of the trauma team arrived to the resuscitation area with minimal delay. Health professionals were well prepared and were aware of their roles and responsibilities for managing specific conditions.

**Emergency Department Survey 2016**

The trust scored better than other trusts for one of the five Emergency Department Survey questions relevant to safety. The trust scored worse than other trusts for no questions and “about the same” as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>9.2</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>7.2</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was consistently worse than the overall England median over the 12 month period from September 2017 to August 2018. The trust performance showed a trend of decline from 14 minutes in September 2017 to 30 minutes in December 2017. The trust then showed a trend of improvement from December 2017 to 13 minutes in the latest month of August 2018.

Ambulance – Time to initial assessment from September 2017 to August 2018 at University Hospital Southampton NHS Foundation Trust

![Graph showing median time from arrival to initial assessment]

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

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

SOUTHAMPTON GENERAL HOSPITAL

From October 2017 to March 2018 there was no trend, however from April 2018 to September 2018 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Southampton General Hospital reaching 27.0% in the latest month.

Ambulance: Number of journeys with turnaround times over 30 minutes - Southampton General Hospital
Ambulance: Percentage of journeys with turnaround times over 30 minutes – Southampton General 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 September 2017 to August 2018 the trust reported one “black breach” in the week starting 19th February 2018. There were no beds available.

(Source: Routine Provider Information Request (RPIR) – Acute - Black Breaches tab)

The trust had undertaken extensive work to ensure patients arriving by ambulance were handed over as quickly as possible in order ambulances could return to service to treat pre-hospital patients. A policy of “No-stacking” meant the department was required to use a dedicated clinical area effectively. The “Pit-stop” allowed for the timely handover of care of patients arriving by ambulance. Nurses were trained to undertake rapid assessments of patients, supported by a consultant. Patients were triaged and clinically assessed and clinical interventions such as electrocardiograms, blood tests or radiological procedures including x-rays and computerised
tomography (CT) imaging could be requested within the “Pit-stop” area. During our inspection we observed the Pit-stop area working effectively. Ambulances could handover the care of their patients with minimal delays. Ambulances were not left queuing for any extensive period of time.

Nurse staffing

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

Staffing was planned to include senior nurses to take charge of and coordinate the department, experienced nurses to triage patients and deliver care and support workers to complete diagnostic tests which helped increase nurse availability. The department also utilised advanced care practitioners across the department.

We looked at nursing rosters and noted there was a good skill mix included in shifts. This included a range of senior and junior nurses as well as advanced care practitioners and support workers. Rosters were planned in advance and annual leave was managed separately by band 7 nurses and approved in advance of the roster. Matrons held monthly band 7 1-2-1 meetings where annual leave and performance matters were discussed and resolved.

The trust reported the following qualified nursing staff numbers as of April 2018 to August 2018 for urgent and emergency care by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southampton General Hospital (SGH)</td>
<td>146</td>
<td>133</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From September 2017 to August 2018, the trust reported a vacancy rate of 5.9% for qualified nursing staff in urgent and emergency care.

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

Senior managers reported a 12.86% vacancy rate across the registered nursing cohort as of December 2018 (Data request WL052 refers). The increased vacancy rate was related to an increase in the underlying establishment of the department; a small number of nurses on secondment to other roles in the hospital allowing them development opportunities and maternity leave. Senior nurse leaders continued to forecast staffing requirements across the department to ensure staffing was maintained to an optimal and safe level.

Turnover rates

From September 2018 to August 2018, the trust reported a turnover rate of 16.9% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 12.0%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From September 2017 to August 2018, the trust reported a sickness rate of 3.6% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 3.4%.

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

Bank and agency staff usage

From September 2017 to August 2018, the trust reported that 8.4% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 4.0% of shifts were filled by agency staff.

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

Medical staffing

All staff we spoke with told us there was sufficient consultant cover in the emergency department with good arrangements to cover the department out-of-hours. The department had recently introduced an additional consultant shift to cover the department between 22:00 and 04:00. We were told consultants regularly stayed later than their allocated hours and often called the department to check on patients. Staff also told us they could access consultants very easily by telephone if required and were always encouraged to do so by the on-call consultant.

Paediatric emergency medicine consultants were rostered to the children’s emergency department throughout each day to review the children and consider admission onto a ward in consultation with consultants from the children’s hospital.

Some staff reported challenges with staffing the junior doctor rota; in part this was linked to the limited number of training places offered by the local medical deanery. The trust worked to recruit non-trainee grade doctors to support the department and to mitigate against the risk.

The trust reported the following medical staffing numbers as of April 2018 to August 2018 for urgent and emergency care by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southampton General Hospital (SGH)</td>
<td>66</td>
<td>69</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From September 2017 to August 2018, the trust reported a vacancy rate of 1.9% for medical staff in urgent and emergency care. The trust did not provide vacancy rates for nursing at the trusts other sites.
As of December 2018, the trust reported the medical vacancy rate as 1.96% made up as follows:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Staff Group</th>
<th>budget Dec18</th>
<th>SIP Dec18</th>
<th>Vacancy FTE</th>
<th>Vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>188 ECM AMU Medical Staff</td>
<td>Medical and Dental/Consultants</td>
<td>9.70</td>
<td>8.83</td>
<td>0.88</td>
<td>9.02%</td>
</tr>
<tr>
<td>188 ECM AMU Medical Staff</td>
<td>Medical and Dental/Trainee Grades</td>
<td>13.00</td>
<td>15.93</td>
<td>-2.93</td>
<td>-22.55%</td>
</tr>
<tr>
<td>188 ECM Emergency Dept Medical</td>
<td>Medical and Dental/Career/Staff Grades</td>
<td>5.80</td>
<td>5.61</td>
<td>0.19</td>
<td>3.23%</td>
</tr>
<tr>
<td>188 ECM Emergency Dept Medical</td>
<td>Medical and Dental/Consultants</td>
<td>19.75</td>
<td>20.23</td>
<td>-0.48</td>
<td>-2.41%</td>
</tr>
<tr>
<td>188 ECM Emergency Dept Medical</td>
<td>Medical and Dental/Trainee Grades</td>
<td>41.90</td>
<td>38.47</td>
<td>3.43</td>
<td>8.19%</td>
</tr>
<tr>
<td>188 ECM Out of Hours Medical Team</td>
<td>Medical and Dental/Career/Staff Grades</td>
<td>5.00</td>
<td>4.21</td>
<td>0.79</td>
<td>15.88%</td>
</tr>
<tr>
<td>188 ECM Out of Hours Medical Team</td>
<td>Medical and Dental/Consultants</td>
<td>1.00</td>
<td>1.00</td>
<td>0.00</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>96.15</strong></td>
<td><strong>94.27</strong></td>
<td><strong>1.88</strong></td>
<td><strong>1.96%</strong></td>
</tr>
</tbody>
</table>

**Turnover rates**

From September 2017 to August 2018, the trust reported a turnover rate of 17.7% for medical staff in urgent and emergency care. This was higher than the trust target of 12.0%.

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

**Sickness rates**

From September 2017 to August 2018, the trust reported a sickness rate of 2.1% for medical staff in urgent and emergency care. This was lower than the trust target of 3.4%.

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

**Bank and locum staff usage**

From September 2017 to August 2018 reported that 6.4% of medical shifts in urgent and emergency care were filled by bank staff and 0.0% of shifts were filled by locum staff.

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

**Staffing skill mix**

From July 2018 to July 2018, the proportion of consultant staff reported to be working at the trust were slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was lower than.
Staffing skill mix for the 61 whole time equivalent staff working in urgent and emergency care at University Hospital Southampton NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>47%</td>
<td>32%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>24%</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 appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

There was good governance around the use of computers at the central work station. Each nurse and doctor had their personal login to access patient information. The screen automatically locked if not used for a short period of time.

We reviewed ten patient records in the adult emergency department to include five patients treated through the majors’ pathway and five through the mental health pathway. We found all information, including clinical data, was written and managed in a way that kept patients safe. Allergies, pain scores and early warning scores were completed and recorded in all patient notes. Administered medicines were recorded and evidenced the medicine and dose given, as well as the name of the nurse who administered it.

We reviewed nine paediatric patient records and all were completed to a good standard. The notes were legible, complete, signed, timed and dated and included doctor’s General Medical Council registration number. Each record included any allergies and the child’s actual weight.

Medicines

Medicines including controlled drugs and intravenous fluids were stored securely.
Fridges and medicine room ambient temperatures in all areas were recorded daily and the log showed they remained within a safe temperature range.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs and their storage and dispensing are regulated by legislation. Controlled drugs should be kept in a separate locked cupboard with those keys kept separately from the main cupboard keys; counted twice daily and when dispensed, signed by two members of staff in a separate controlled drugs register. We checked controlled drugs and confirmed that this procedure was followed in accordance with safety guidelines.

Patient group directions (PGDs) were in place and nurses could prescribe simple analgesia and other medicines including nebulisers and local anaesthetics. A PGD is a prescription signed by a doctor and agreed by a pharmacist, which acts as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients.

We observed nursing staff preparing medicines in a safe way, adopting aseptic-non-touch-techniques for the preparation and administration of intravenous medicines.

Medicines and equipment for use in emergencies were readily accessible to staff and were checked daily as per the hospital’s policy.

NHS prescription stationery (FP10) was stored securely and usage of individual prescriptions was tracked. Staff were able to access up to date guidance and references relating to medicines such as British National Formulary to administer medicines.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Between December 2017 and November 2018, the emergency department (including the clinical decision unit) reported 1,198 incidents. Details of the level of harm can be seen below.

We reviewed three route cause analysis reports associated with serious incidents which had occurred across the emergency department. Reports were detailed, contained clear chronologies and explanatory notes. Areas of good practice were identified as were any opportunities for lessons learnt. There was evidence that families and patients were involved in investigations.
Staff spoke with confidence about how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.

Information about incidents (referred to as adverse event reports within the trust) was shared with staff via meetings, email and during handovers. Each member of staff we spoke with told us they were encouraged to report incidents even if they were not sure whether it constituted an incident. They said there was no sense of blame attached and each incident was considered as a learning experience. Senior members of staff told us they encouraged staff to report incidents as there was always something to be learnt from them. There was evidence of incidents being considered at clinical governance meetings. Scrutiny of incidents involving specific patient groups such as those presenting with mental health concerns were reviewed at clinical governance meetings, as were incidents involving staffing shortfalls, needlestick injuries and health and safety incidents. The ED governance group captured specific actions via an action log which was kept under monthly review. This enable the department to consider progress against specific themes such as violence or aggression towards staff in the department. Where actions or mitigations had proved to not be successful, there was evidence of alternative actions being considered.

Staff feedback following incidents was good with staff receiving regular feedback and learning points from incidents. Staff could describe learning action points from incidents. The introduction of streamlined falls risk assessments was described by nursing staff as having a fundamentally positive impact to the way patients at risk of falls were identified and managed within the department. Falls risks assessments and supporting actions were recorded and demonstrable during the inspection. Comprehensive analysis of all falls in the department was undertaken and considered the nature of fall, impact of harm, actions taken pre and post fall including whether initial assessments had been completed. There had been significant reductions as in the number of falls sustained across Division B (which included emergency medicine and the clinical decision unit).
Staff had a good understanding of the duty of candour regulations. Staff were aware of the importance of being open; our interviews with staff and analysis of incidents suggested staff applied the statutory duty of candour test even when the legal threshold was not met. Staff could describe the actions and support afforded to patients in line with regulatory requirements.

Evidence of change was apparent within the department because of incidents having been reported. This included the introduction of a privacy and dignity room within the majors’ area. This room was designated for the use of patients prone to over-stimulation, or for those living with dementia or who had learning disabilities. We observed this area being used appropriately. Although not formally monitored, staff described a reduction in the number of incidents involving vulnerable patients since the introduction of the privacy room.

In 2018, staff started contributing anonymised reports about ‘Near Miss’ (near death) drug related incidents to a central electronic portal, as requested by the substance misuse commissioners. The consultant nurse set the agreed reporting threshold as being any patient who required care in the resuscitation room in ED. Participation in this project enhanced the public health / health promotion role of VAST, going beyond interventions with individual patients.

Morbidity and mortality meetings occurred regularly in the department. Cases were identified and reviewed by a range of health professionals to determine the level of care provided to patients. Learning points were identified and communicated to staff. Themes were identified and changes to practice occurred where appropriate.

The ED and Acute Admissions Unit (AMU) team (consultant nurse, emergency medicine consultant, VAST practitioner and AMU matron) met weekly with the head of UHS security, the MITIE security account manager (based at UHS to manage the security team), the duty security supervisor, the UHS head of health and safety, one of the Hampshire police mental health leads and the Hampshire police hospital liaison officer to discuss incidents of violence and aggression that had been reported via the incident reporting system in ED and AMU in the previous seven days. Information was reviewed about the cause of the violence and aggression, what actions staff had taken, whether the incident was reported to the police and what outcomes there were from proceedings in the Criminal Justice System (if applicable). The group discussed if any lessons could be learnt to prevent reoccurrence. Staff who reported incidents of violence and aggression received a letter from the ED consultant nurse, signposting them to sources of support.
Never Events

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

From September 2017 to August 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from September 2017 to August 2018.

Of these, the most common types of incident reported were:

- VTE meeting SI criteria: two incidents
- Apparent/ actual/ suspected self-inflicted harm meeting SI criteria: one incident

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

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

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from September 2017 to September 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and could evidence its effectiveness.

People’s care and treatment was planned and delivered in line with up to date evidence-based guidance and standards set by organisations like the National Institute for Health and Care Excellence (NICE), Surviving Sepsis Campaign, British Thoracic Society and the Royal College of Emergency Medicine. Guidance was regularly discussed at team meetings, and regular audits were completed and learning opportunities shared with staff.

The ED governance group considered changes to practice because of changes to national best practice guidance or local audit results. There was evidence the team closely scrutinised changes to practice. For example, the age in which VTE assessments and treatment should be carried out was reduced by NICE from 18 to 16. Clinical staff in ED identified the recommended anti-coagulant therapy was not licensed for use in those under 18 years of age. The team referred the query to the trust-wide VTE (clot) committee however a review of the action tracker
suggested no response had been received. The ED team continued to monitor the number of cases that presented to the ED to determine any potential impact to 16-18-year olds.

We looked at a variety of clinical policies and guidelines during the inspection within the emergency department (ED) and on the trust intranet. We saw policies were in date and based on National Institute for Clinical Excellence and best practice guidelines.

Staff used local guidance alongside internationally developed tools to help screen and manage patients presenting with issues such as trauma or sepsis. They also monitored how well staff followed guidance when caring for patients and where appropriate, liaised closely with local commissioning groups, keeping them informed of progress in relation to care standards. For example, the department had worked to deliver a Commissioning in Quality and Innovation (CQUIN) project associated with compliance of patient safety across the delivery of safe sepsis management.

A range of clinical care pathways and proformas had been developed in accordance with national guidelines. These included treatment of stroke, sepsis, asthma, fractured neck of femur (broken hips), acute coronary syndrome and mental health problems. We found these were understood by staff and were being used effectively to manage patients’ care. For example, psychological assessments were carried out following any episode of self-harm which was consistent with NICE guidance. The psychiatric liaison team and the VAST team could offer patients brief interventions.

Staff told us and could demonstrate that clinical guidelines were easily accessible and were regularly updated. The department informed staff of updates to guidelines on notice boards, at board rounds and on display boards which were located across the department. Junior doctors reported receiving four hours of protected training time each week in which clinical guidelines and changes to practice could be discussed.

We saw examples of national guidelines (such as Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2016) being referred to in local policies and procedures. We observed three episodes of care in which patients were managed and treated in line with the sepsis policy. This included a timely initial assessment, administration of antibiotics within one hour, administration of oxygen and strict monitoring of the patient’s fluid balance (the amount of fluid provided to the patient measured against the amount of urine the patient passed).

There were several patient groups with a mixture of mental health, substance misuse and chronic medical problems that benefited from a consistent response from health professionals. To help frequent attenders to the ED, monthly meetings called, “The high intensity service users’ group”, chaired by an ED consultant had been established. In the meeting, patients were discussed and a care plan was agreed which may alter behaviours and contribute more constructively to the patient’s needs. For example, some patients who were well known to services may have benefited from a low-key response from the ED, without formal review by liaison staff, but a timely alert to their community team. In other cases, strategies to avoid admission or over-investigation were recognised as benefiting the patient. These care plans were actively managed by the ED chair of the meeting or a nominated clinical lead. Clinicians attended the meeting from the ED, specialities as required from the trust, mental health, primary care and community services, including the police and ambulance service. Input from patients was encouraged always.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Hydration and nutrition risks were routinely assessed for each patient on the short stay assessment unit. Staff used a range of nationally recognised tools including ‘MUST’ (malnutrition universal screening tool).

Water was available in all areas of the department and patients had drinks to hand. We observed a member of the housekeeping staff regularly offering hot or cold drinks, sandwiches and hot meals to patients.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.2 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 (October 2016 to March 2017; published October 2017)

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain

Patients told us they were offered pain relieving medicine on a regular basis. We reviewed 14 adult and paediatric records all of which recorded regular assessments of pain. A simple numerical pain score was used and recorded. Staff were able to direct us to age appropriate pain scoring systems which could be used for young children and those who could not verbally communicate.

In the 2017/18 Royal College of Emergency Medicine (RCEM) Fractured neck of femur audit, Southampton General Hospital emergency department failed to meet the RCEM fundamental standard of 100% of applicable patients having a pain score assessed within 15 minutes of arrival. However, the hospital was in the median quartile when compared nationally.
The department was in the upper quartile for ensuring analgesia was offered to patients within twenty minutes for those assessed as being in severe pain.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.9 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same other trusts.

The trust scored 7.9 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Patient outcomes**

**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, Southampton General Hospital emergency department failed to meet any of the national standards.

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

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 21.0%; UK: 19%.
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 PO or 100mg hydrocortisone IV
- Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
- Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Standard 5b (fundamental): within 4 hours (moderate). This department: 44.8%; UK: 28%.

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

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 12.0%; UK: 25%.
- 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: 34.3%; UK: 52%.

The department had reviewed its performance against standard 3 to help improve compliance. A review of practices identified delays in doctors attending the pit-stop area to prescribe nebulisers and also staff were not routinely recording whether nebulisers had been administered by ambulance crews’ pre-hospital. Actions included the introduction of a patient group direction which enable nursing staff to commence nebulised therapy without delays. Additionally, a doctor had since been introduced to specifically provide care and treatment in the pit-stop area thus reducing the need to seek a doctor from another area of the emergency department.

The department had reviewed its performance against standard 9 and considered an intentional clinical deviation from the RCEM recommended dose of oral prednisolone was likely to be the cause of the low audit result. The department had reviewed the cases submitted to the national audit and considered 78% of applicable patients had been discharged on a course or oral prednisolone as compared to the reported 34.3%.

The department’s results for the remaining three standards were all within the middle 50% of results.

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats (saturation level)94-98%. This department: 21.0%; UK: 19%.
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 24.0%; UK: 26%.
- 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 PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
    - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 28.2%; UK: 19%.
RCEM Audit: Consultant sign-off 2016/17

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

The department was in the upper UK quartile for two standards:
- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 24.0%; UK: 8%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 19.8%; UK: 10%.

The department was in the lower UK quartile for no standards.

The department’s results for the remaining two standards were all within the middle 50% of results.
- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 18.6%; UK: 11%.
- 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: 23.1%; UK: 12%.

RCEM Audit: Severe sepsis and septic shock 2016/17

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

The department was in the upper UK quartile for no standards:

The department was in the lower UK quartile for no standards:

The department’s results for the all three standards were all within the middle 50% of results:
- 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: 63.5%; 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: 75.0%; 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: 36.0% UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 69.2%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 34.6%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one
hour of arrival. This department: 33.7%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 35.0%; UK: 44.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 24.5%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

Although the nationally published results for the severe sepsis audit placed the trust in the average median across each of the eight standards, clinical staff reported disappointment at their performance as they had previously performed significantly well against a national CQUIN for the management of sepsis. The trust was in receipt of correspondence from NHS England detailing the fact the trust had been one of the most improved performers nationally against the recognition and management of septic patients.

The department assigned a junior doctor to extensively review the data submitted against the severe sepsis audit. The review identified significant issues with the quality of the dataset. The review acknowledged areas for improvements which had since been instigated in the department. This included better nursing documentation and recording of interventions, the introduction of a doctor to the Pit-stop, and improved referral processes to the outreach team when patients did not specifically require intensive care but would have benefited from high dependency; an area of service provision which the trust currently does not have.

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

From September 2017 to August 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average except for October 2017 when the trust performance was 45.8%. This may be due to trust data issues.

Unplanned re-attendance rate within seven days - University Hospital Southampton NHS Foundation Trust

(Source: - A&E quality)
Competent staff

There was protected pre-planned training time for junior doctors each week. Specialty doctors in training told us the ED was a good place to work with approachable and supportive consultants, good supervision and good access to practical teaching and learning opportunities.

The trust supported continued professional development of its staff, including formal qualifications, practical training, conference attendance, secondments, team days, mentoring and shadowing opportunities with other specialties. There were opportunities for leadership and management training for senior nurses and clinicians.

There were extensive staff development programmes available, providing specialist education and skills training to further develop staff skills and competence. This was accessed via the university education department and in-house education team.

The knowledge and skills base across all bands of nursing and medical staff was appropriate to the departmental and patient requirements. These skills, such as advanced life support, were well-documented on a training record and within staff records.

Supervision took place at regular intervals between junior staff and their mentors. This gave the opportunity for individual staff performance to be identified and managed.

Nursing staff and allied health professionals described the access to post-graduate education as excellent. The department had been dynamic in developing alternative professional development pathways including encouraging staff to undertake the advanced care practitioner course. Nursing staff and advanced care professionals were trained to undertake advanced procedures including the management of patients who presented with acute coronary syndromes. We observed nursing staff managing specific clinical cases with good support provided by consultants.

Health support workers had been trained to also undertake advanced skills as part of delegated duties and responsibilities. We observed very close supervision of health support workers by registered health professionals. Support workers spoke positively about the opportunities they had been afforded to help them progress professionally.

The children’s emergency department was staffed by qualified children’s nurses 24 hours a day. The department employed four specialist paediatric emergency medicine consultants who supported the children’s ED whilst also liaising closely with the children’s hospital. Registered adult nurses were provided opportunities to work alongside the children’s team to enable them to develop their competencies for the assessment and management of the sick child.

Twelve health care assistants had received training in dementia and were recognised as dementia champions. Staff working across the emergency department had good knowledge of the procedures and policies to support people in crisis.

Staff in the VAST team had extensive training during a nine day induction which included training in dignity in care and The Human Rights Act, regulation and national standards, the Mental Capacity Act and Deprivation of Liberty Safeguards, confidentiality and information sharing, multi-agency partnership working, frequent attendees, caring for the children of vulnerable adults, caring for the carers of vulnerable adults, safeguarding vulnerable adults, dementia, learning disability,
Physical disability and sensory impairment, mental illness, domestic abuse, stranger violence and hate crime, sexual violence, honour based violence, alcohol misuse, Illicit drugs, homelessness, asylum seekers, human trafficking and people engaged in prostitution. This ensured the VAST team were a highly skilled and knowledge team who worked in partnership with members of the emergency department to support the needs of vulnerable patients.

**Appraisal rates**

From September 2017 to August 2018, 86.2% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 92.0%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified ambulance service staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>104</td>
<td>92</td>
<td>88.5%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>162</td>
<td>137</td>
<td>84.6%</td>
<td>No</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Multidisciplinary working**

There existed excellent MDT and Interagency working to support the needs of vulnerable patients. Staff in the ED, both acute and mental health, worked very closely together, discussing assessments, risks and care plans. Discussions included referring patients to the community mental health teams or a request for an assessment under The Mental Health Act. Staff within the ED were highly complementary about the MDT and other supporting agencies. For example, regular mental health case review meetings took place between ED staff, the local mental health trust, AMHPs, ambulance service, police and commissioners. VAST worked closely with police, probation, housing, social care, women’s’ health (crisis centres and refuges), mental health and primary care to ensure referral and support pathways were accessible and utilised.

The hospital had developed a frailty team who provided rapid assessments of patients in the ED who met certain referral criterial. We observed the multi-disciplinary frailty service, which comprised physiotherapists, occupational therapists, therapy assistants and nurses. Their role was focused around improving the urgent care pathway for older people and those living with frailty. We observed members of the team working alongside the nursing and medical staff in the ED. They undertook rapid assessments of individuals to determine what support and care people may have required prior to being discharged home. We observed the team supporting individuals who had sustained injuries following falls at home; patients were provided with mobilisation equipment such as walking frames after having been assessed.

There was exceptional support and close working relationships between specific specialities. For
example, we observed medical speciality doctors providing in-reach support to the emergency department. Stroke teams were available 24 hours a day and were present to receive patients in the resuscitation room when the hospital had been pre-alerted to the arrival of the patient by the local ambulance service. Stroke teams provided rapid care and assessments with appropriate support from the ED team. Health professionals were observed placing patients at the centre of care which ensured all those involved in the treatment of patients remembered the importance of treating patients as individuals whilst also following agreed treatment protocols.

Staff in ED, the vulnerable adult support team, child and adolescent mental health teams and psychiatric liaison told us that they worked well together and there was open information sharing and excellent working relationships and communication.

The emergency department was heavily involved in multiple research programmes which were often co-ordinated by other medical specialities. We observed close working relationships between specialist research nurses and the ED team. This ensured research programmes could be applied in emergency care.

Examples included participation in a joint research programme for the safe and rapid management of chest pain; a research project undertaken by the emergency department and the trauma and orthopaedics team. The ED team were working alongside the paediatric team to assess the effectiveness of shorter course of specific medicines in the management certain clinical conditions. The presentation of children with the identified clinical conditions to the emergency department meant the paediatric team had greater opportunity to increase the total exposure of their research programme, thus providing greater clinical evidence. The ED team was supported in their research programmes by specialist research nurses who were observed to be present in the ED during the inspection.

**Seven-day services**

The department provided care to adults and children 24 hours a day, 365 days a year. Patients had access to diagnostic services such as x-rays and pathology 24 hours a day, seven days a week. Staff we spoke with stated they felt there were no issues in accessing these services at any time of the day.

**Health Promotion**

The service supported patients by promoting healthier lifestyles by identifying those who may need extra support during assessment and sourcing the right staff to help provide specialist care for them.

Staff were observed signposting patients to relevant health promotion services during clinical interviews. Additional information was provided to patients which directed individuals to smoking cessation and weight loss support groups.

There were a wide range of patient information leaflets accessible in the main department.

Staff discussed the emphasis they placed on enabling patients to take control of and improve their health. They described this being particularly important with vulnerable patients and the
impact health promotion has with chronic diseases, mental health, physical activity and nutrition, for example. Staff in VAST were trained in motivational interviewing.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff had access to best practice reference guides and trust policies in relation to assessing capacity.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

All staff had received training on The Mental Capacity Act (MCA) and Deprivation of Liberty safeguards. Without exception staff could describe and understood relevant consent and decision-making requirements of legislation and guidance including the MCA and the Children’s Act. Every patient received a capacity assessment and we saw staff assessed capacity on decision specific basis. Staff recognised the difference between lawful and unlawful restraint practice and used an anticipatory request under MCA to restrain if attempts were made for a high-risk patient to leave ED.

Staff were observed seeking consent from patients prior to the commencement of any clinical intervention. Staff were seen recording in patient records when informed consent had been gained from a patient.

We spoke with nine members of staff who were able to tell us the actions they would take if they had concerns about an individual's mental capacity. Staff working with children and young people were knowledgeable about the concept of Gillick competence and Fraser guidelines. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so, often referred to as being Gillick competent. Staff were aware that should a child not be considered “Gillick competent”, consent would be sought from the child’s parent or guardian. Staff could also describe the scenarios in which an individual would be deemed to have parental responsibility.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from September 2017 to September 2018, Mental Capacity Act (MCA) training was completed by 79.4% of staff in urgent and emergency care compared to the trust target of 85.0%.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We spoke with twenty-three patients and relatives, all of whom were highly complementary of the care and treatment they had received. Patients consistently reported they had been treated with dignity and respect. We were approached by patients on several occasions in order they could share their experiences and views with us. Comments included “The staff have listened to me, treated me as an individual and showed a real interest in why I came here today”; “I could not have asked for better care and treatment. Staff have been responsive and compassionate”.

Throughout the inspection we observed staff speaking in appropriate ways with patients. Staff adapted their body language to enable them to communicate more effectively with patients. For example, we observed a consultant lower themselves to their knees to enable them to make appropriate eye contact with a child in the emergency department. We observed an episode of care during which a senior nurse and a consultant were speaking to an unconscious patient; this was despite the patient not being able to respond.

Staff used curtains around the bed spaces to provide privacy when assessing and treating patients, and ensured patients’ dignity was maintained when curtains were opened. Patients were covered up at all times when they were in the department and when patients were transferred from the ED.

Staff were observed introducing themselves by their first names; this was a consistent and embedded practice across the department.

Reception staff were observed providing reassurance to patients when they presented to the reception desk. Reception staff prompted other patients and relatives to step back from the reception window when other patients were being booked in; this ensured the privacy of patients.

The trust encouraged patients and staff to provide feedback on their experiences of using different services and for interacting with other specialties across the hospital. We reviewed a range of “Favourable event reporting forms” (FERFs). Comments from the feedback included:

- “That just listening and valuing what patients/carers are saying and being efficient in doing what you say you will do rather than just addressing what may initially seem like the cause of a problem will give patients and families a better experience even if the eventual outcome isn’t so positive.”

- “Aided flow and moral in department”

- “Phone call from the Emergency registrar in Majors, calling to wish the Paediatric Team Merry Christmas and check that the Junior Doctor was okay and supported by someone one senior, positive tone on phone and offered to come around to help if we needed.”

- “The Critical Care Outreach team were giving a patient respiratory support in ED resus when beds were limited on GICU. The ED staff that night in resus were an excellent team, really helpful and caring to both the patient and us. Thank you”
“[Staff member] kindly and calmly assisted the Stroke team to safely sedate a distressed patient who needed a time critical CT A for potential TPA. Thank you.”

We observed episodes of care during which patients were truly respected and valued as individuals. Patients were empowered as partners in their care both practically and emotionally. This was especially the case for those patients who presented with mental health conditions or those patients who were recognised as vulnerable. Staff de-escalated anxious patients through non-physical techniques. Members of the vulnerable adult support team had been trained to use motivational interview techniques; this technique enabled staff to help patients to change or alter their behaviour by helping people to overcome ambivalence about a particular course of action.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from September 2017 to August 2018. The trust had a low number of responses for April 2018 so does not display in the graph below.

A&E Friends and Family Test performance - University Hospital Southampton NHS Foundation Trust

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw staff involve both patients and those close to them in their own care, allowing time to
answer any questions. We also saw staff spending time with loved ones in the relatives’ room explaining the care being delivered. Following an incident, the department had created an additional clinical space within the majors’ area which could be used for those patients prone to over-stimulation, or those individuals living with dementia or those with learning disabilities. This area was observed to be used appropriately.

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 involved patients and those close to them in decisions about their care and treatment.

Staff were available to speak with family members to explore treatment options where appropriate, including the use of ‘do not attempt cardiopulmonary resuscitation’ orders.

Emergency Department Survey 2016

The trust scored better than other trusts for no of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for all 24 questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. 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>Q17. 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>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>you could understand?</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Facilities and premises were appropriate for the services being delivered.

The service was accessible and sign-posted from the main road and the main hospital entrance. There was suitable parking (including disabled parking) close by. Signage was also available throughout the hospital which helped visitors find their way to the department.

The large reception area at the front was clearly visible for visitors. Waiting areas were large and had enough seating for patients. Vending machines containing a range of foods were available and well stocked.

Reception desks had been designed so they were accessible for patients in wheelchairs.

From the waiting area, patients were streamed to specific pathways depending on the clinical need of the patient.

A five bedded “Pit-stop” area allowed for the quick handover of patients relayed to the hospital by ambulance. The trust had adopted a “No stacking” policy which enabled local NHS ambulance trust to redeploy their ambulances to the pre-hospital setting with minimal delays. Patients were clinically assessed and treatments commenced in the pit-stop before patients were transferred to the most relevant clinical treatment pathway.

We saw a smaller waiting area for children which was identified with child friendly wall decorations. The area for children was audio-visually separated from the main waiting area. A small range of toys were available for younger children. A new purpose-built children’s emergency department (CED) had opened shortly prior to the inspection. The new CED had been designed with input from children and young people. Whilst not fully operational, there were clearly defined plans to fully open the CED in quarter three of 2019. In doing so, the existing children’s assessment unit would become co-located with the CED. Additionally, the new CED had been designed to ensure treatments could be provided in a timely way. The addition of a dedicated children’s x-ray room and clinical treatment room had all been carefully planned and factored in to the new department.

The trust made a significant financial investment to establish and build an appropriate environment for the management and care of patients who presented with mental health needs. The enhanced care suite had opened in September 2018. The ECS was a purpose built, two bedded clinical area which was used to treat patients with a range of conditions. Careful consideration had been given to ensure the ECS met service specifications. Both rooms were minimally but comfortably furnished, contained no ligature points and permitted the close observation of patients. The unit was staffed twenty-four hours a day by a qualified mental health nurse and health support worker. Staff reported that since the opening of the ECS, the reliance of rapid tranquilisation, whilst rare, had further reduced, in part because of the ability to nurse patients in low stimulus environments.

The department accessed an interpreting and translation service for those whose first language was not English or where patients required a British Sign Language interpreter.
Meeting people’s individual needs

The service took account of patients’ individual needs.

In response to an ageing population, the ED introduced twelve dementia champions who worked to raise awareness of those living with dementia and were available to offer advice and support to staff, patients and carers during their time in the department. There was a “forget me not” system in place which alerted staff to patients who may be experiencing memory problems or confusion. Staff told us they knew to allow more time for these patients when speaking with them and helping them to understand what was going on. They also said they offered additional support with tasks where needed; for example, with eating, drinking, going to the toilet and being accompanied to different departments across the hospital. Dementia boxes containing distraction materials and was held by the dementia champions. Staff could access support materials to help aid communication with those individuals who may have lost their ability to communicate verbally.

Patients with an identified learning disability were flagged on the electronic system. Triage nurses told us they could place prompts on the electronic system if a patient with learning disabilities presented to the department and who was not previously known to the trust. There was a process to fast-track specific vulnerable patient groups through the emergency care pathway in order patients remained in the department for as little time as was clinically required.

Pump prime funding for an emergency department child and adolescent mental health (CAMHS) nurse was gained through the ED first pump prime bid (Pump prime funding is defined as the process of investing small amounts of government funds in to a depressed economy or underinvested service provision in order to spur additional growth). The role was so successful in the first year that it was permanently adopted and financed recurrently by the trust. ED staff formed part of the CAMHS task and finish group which met monthly.

The new Children’s ED had factored in and introduced a low stimulus / safe room as part of its service provision. Due to the very recent move of the children’s emergency department, the low stimulus room was not being used at the time of inspection however we noted staff mitigated against this by ensuring those patients requiring a low stimulating setting were nursed in appropriate cubicles within the main children’s emergency department.

A comprehensive and extensive fact sheet was available in ED to sign post current military and veteran personnel requiring support from a variety of organisations including those providing mental health services.

One member of the VAST team had been allocated as the professional lead for homelessness. They VAST team were reviewing VAST interventions for homeless patients (and those at risk of homelessness). This included reviewing the quality of the VAST team’s interventions, gathering evidence about the nature and extent of the problem to help the ED review referral pathways and lobby for more resources. Staff had drafted standard operating procedures for the management of homelessness in ED and a patient information leaflet about staying safe on the streets. Training had also been provided to all ED staff.

Alongside homelessness, drug use was recognised as a regular reason for referral to VAST practitioners. All patients attending the ED were screened and risk assessed to determine whether they were regular users of recreational or illicit drugs. Relevant patients were provided with information, signposted to support services. Appropriate inter-professional referrals and
safeguarding interventions were made. Where appropriate, the VAST practitioners utilised the Drug Use Disorder Identification Test. This was an internationally recognised assessment tool and enabled health professionals to screen for problematic substance use and to undertake a detailed assessment of an individual’s needs. In addition to the interventions above, the team commonly liaised with community providers (with patient consent) to confirm current replacement therapy (methadone etc) and passed information to the ED clinicians to inform prescribing decisions at UHS. They also signposted clinicians to the trust’s replacement therapy protocol.

A well-decorated and well-sited viewing room was available for friends and relatives to spend time with deceased patients. The room was equipped with soft lighting, air conditioning and sufficient seating to accommodate several visitors. The room was located within the emergency department but away from the busy clinical areas so people were not distracted by noise.

We noted that due to the design of the department, patient privacy was not always maintained when they were being assessed at the triage stage. This was because the triage room contained two triage stations therefore allowing for two patients to be triaged by different nurses simultaneously. There were no dividers between the two triage bays and so patients and relatives could overhear other patient’s conversations when they were being triaged.

Emergency Department Survey 2016

The trust scored better than other trusts for none of the three Emergency Department Survey questions relevant to the responsive domain. The trust scored about the same as other trusts all three questions.

<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>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for any of the 12 month period from September 2017 to August 2018. The trust performance ranged from 68 to 92 minutes which was constantly worse than the standard and England average (which ranged from 56 to 64 minutes).

Median time from arrival to treatment from September 2017 to August 2018 at University
Hospital Southampton NHS Foundation Trust

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 October 2017 to September 2018 the trust failed to meet the standard and performed worse than the England average for seven months during the 12 month period.

Four hour target performance - University Hospital Southampton NHS Foundation 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 October 2017 to September 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently better than the...
England average.

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

![Graph showing percentage of patients waiting more than four hours from the decision to admit until being admitted.](image)

(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 October 2017 to September 2018, 13 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over four hours were in December 2017 (333), January 2018 (343) and February 2018 (384).

(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 September 2017 to August 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently worse than to the England average.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - University Hospital Southampton NHS Foundation Trust**

![Graph showing percentage of patients that left the trust’s urgent and emergency care services without being seen.](image)
Median total time in A&E per patient (all patients)

From October 2017 to September 2018 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average.

Median total time in A&E per patient - University Hospital Southampton NHS Foundation Trust

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

Year on year, activity within the Southampton general emergency department had increased. Staff working across the department acknowledged the increase in activity and considered they were at peak capacity in terms of the number of beds and clinical treatment areas available. Service reconfiguration had been considered and plans had been developed to improve the layout of the department. However, there was little footprint capacity to enable the creation of more and better
sized majors’ cubicles. This was recognised as a risk for the department who mitigated against associated risks (as detailed in the safe domain).

Departmental flow and the emergency access target was considered a “Trust-wide” target. We observed excellent working relationships with medical and surgical specialities who attended the department when required to review and assess patients. Some staff reported delays with some specialities attending the department however these incidents were rare and addressed quickly amongst consultants and via the Chief Executive emergency performance board which took place weekly. The Chief Executive facilitated the weekly meeting to ensure the emergency care pathway functioned as best it could. Quick actions and resolutions were identified and individuals were held to account.

Out of hours mental health provision was available for both children and adults. Psychiatric liaison and child and adolescent mental health (CAMHS) teams worked towards key performance indicators and had established new mental health triage systems to respond in one hour. We noted that during normal working hours this metric was routinely achieved however there was an acknowledgment amongst staff that more work was required for those patients who presented out of hours. In most instances staff said patients who required a Mental Health Act assessment were assessed by an Approved Mental Health Practitioner (AMHP) and Section 12 doctor with minimal delay during the day time. However, staff said out of office hours there could be delays. Delays were also experienced whilst waiting to access an acute mental health bed.

Learning from complaints and concerns

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

Staff we spoke with were aware of the complaints process should someone wish to complain. The management team took complaints seriously. We saw examples of learning from complaints being shared with staff to help improve the service for others. Outcomes were shared so that other staff could learn from the experiences of patients and their loved ones. We saw action plans developed to ensure actions were properly recorded.

We reviewed three complaints, their associated responses and actions plans which had been developed in response to the investigations carried out. Complaint responses were candid and detailed. Each point raised by the three complainants were investigated. Complaint responses were neither defensive nor critical of the patients’ experience. Various health professionals were involved in the investigation of complaints which ensured responses were of a multi-disciplinary nature. Actions were appropriate to the issues identified. Action plans were created and monitored to ensure all relevant actions were instigated.

Summary of complaints

From September 2017 to August 2018 there were 65 complaints about urgent and emergency care. The trust took an average of 52.0 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 35 working days.

- Southampton General Hospital: There were 97 complaints. The following subjects had three or more complaints:
• Attitude of medical staff: 4
• Communication with relatives: 4
• Delay/ failure to undertake scans / x-ray: 4
• Delay/ failure to diagnose (including missed fracture): 3
• Communication with patient: 3
• Communication between medical team: 3
• Delay/ failure in treatment/procedure: 3

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

**Number of compliments made to the trust**

September 2017 to August 2018, there were 10 compliments in urgent and emergency care.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The emergency department was part of Division B which was overseen by a divisional director and head of nursing. At a local level, the emergency department leadership team consisted of a service manager, two clinical leads and a matron. The clinical leads job shared the role and both post holders worked as consultants in the ED; they had assumed the role of clinical lead in September 2018. The new appointment and subsequent transition to a new leadership structure was described as immensely successful and beneficial to the smooth operating and oversight of the emergency department which some staff had described as previously being dictatorial and suppressive.

We considered the leadership team to be cohesive, with heightened visibility and presence across the department and well respected by peers and colleagues. The priorities of different health professions were considered and discussions at governance meetings appeared well rounded. Nursing and medical priorities were aligned and professional standards were upheld and promoted by the leadership team. Clinical effectiveness, safety, patient experience, quality, performance and financial sustainability were all considered equally.

Staff reported the leadership team operated an open-door policy. Leaders were described as being very approachable and responsive to staff concerns. Leaders listened to and acknowledged the concerns of front-line staff. Our discussions with the leadership team suggested they were sighted on and were addressing the challenges of providing emergency care in a challenging estate.

Vision and strategy

Although the department did not have a formalised vision or strategy, in part because of the recent changes to the clinical leadership of the department, all staff we spoke with provided a consistent message that safety, quality and patient experience were paramount.

There was a comprehensive emergency care action plan which was being actioned at the time of the inspection. The action plan considered a range of different workstreams including improvement of departmental and operational flow through the emergency pathway, reduce clinical variation, work to align the existing workforce to ensure it meets operational demands and to work with partners to reduce pressure during evenings and at night time. Each action had a responsible and accountable officer assigned and oversight was provided via the chief executive’s weekly emergency department meeting.

Staff across multiple professions could describe the trust vision and strategy. Staff could describe the organisations ambition to strive to do better for patients each day. Staff believed they were empowered to make changes, no matter the scale, so long as they impacted positively on patients, their experience, the quality of care received and the safety of the department.

Culture
Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We spoke with a range of health professionals who were both new to the department and also those who had previously worked in the department and had since returned. There was a consistent theme of sustained improvement in the working conditions of the emergency department. Whilst some staff felt there remained a greater focus on the four-hour target as compared to the quality, safety and experience of patients, this focus was not the priority for the majority of staff. Staff reported improved working relationships across the nursing and medical professions. The assignment of band seven nurses and consultants to individual workstreams was welcomed with staff being able to demonstrate change as a result of improved working relationships.

Some staff reported challenges with barriers created through the reluctance of the divisional director to consider new ways of working however it was difficult to corroborate this during the inspection. There was a sense staff were empowered to make change as has been reported in the previous section.

Junior doctors reported that senior doctors acted as role models. Consultants were described as strong clinical leaders who advocated for patients. Senior nurses were described and observed to be “Hands-on” with extensive experience of working in emergency care. We observed consultants being pro-actively challenged by junior staff and vice-versa. This challenge was non-confrontational and promoted opportunities for teaching in real time.

A review of departmental risks and reported incidents, and interviews with staff confirmed violence and aggression from patients towards staff was one of the most pressing concerns for the leadership team. Front-line staff reported there was a significant focus from the leadership team on trying to address and mitigate against the risk. This included the on-going pressure on the local police service to bring about criminal cases against those individuals who presented with or carried out acts of violence or aggression towards staff, visitors or other patients.

**Governance**

There was a governance structure in place with clearly defined roles and responsibilities for the emergency department.

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The leadership team were sighted on the challenges of the department. Routine audit programmes, consideration of incidents and complaints and patient feedback were all considered to determine how the department was performing. In-depth analysis of a range of information was considered and scrutinised on a monthly basis. For example, the leadership team consisting of clinicians, nurses and operational staff reviewed all incidents including thematic information associated with falls, violence and aggression incidents, health and safety incidents, complaints, compliments and operational performance. This enabled the team to make changes to service provision or to consider contributory factors which may require redress.

Band seven nurses and individual named consultants were assigned to one of ten pathways consisting of: Minors, Majors, Resus, safeguarding, training and development, triage, clinical decisions unit, paediatrics, vulnerable adults and mental health and pitstop. Verbal updates were
received monthly across a rolling annual agenda. Matrons and clinical leads discussed relevant standing agenda items across each of the clinical pathways at one-to-one meetings which occurred monthly. This approach to delegated pathway management resulted in there being named accountable individuals who could provide assurance and oversight of manageable components of the wider emergency pathway.

Emerging priorities, area updates, policies and documents for review and approval, focus of the month, validation of incidents, new significant incidents, new claims, new significant complaints, favourable event reports and a review of the departmental risk register all featured at monthly governance meetings. Minutes of these meetings demonstrated a high level of discussion and analysis of all information available to the team to determine the overall clinical effectiveness and safety of the department. Action trackers were reviewed monthly to ensure any outstanding actions had been resolved or mitigated against. Any action or concerns discussed during the governance meeting which were of significant concern were identified and captured for escalation to divisional governance meetings; this suggested an acceptable flow of information from front-line to the trust senior management team existed.

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.

The Risk Register was reviewed and updated at every governance meeting. There were four risks currently on the risk register;
- ED capacity – majors and pitstop
- Violence and aggression in the ED
- ED flow impacting on resus capacity
- Inability to achieve the four-hour emergency access target

Each of the four risks were rag rated at 20. Mitigations existed for each of the four identified risks. Action trackers confirmed that mitigations to risks were discussed, reviewed and considered to determine impact. Weekly Chief Executive emergency department meetings occurred; we observed this meeting take place on Tuesday 22 January. Chaired by the chief executive, the meeting was attended by a range of health and operational professionals to examine the trusts weekly performance against the constitutional four-hour emergency access target. Scrutiny of performance was multi-professional and considered days in which performance both met the target but also days when the target was not met; this ensured the trust could extract areas of good practice to help determine future improvements to sustaining compliance against the access target.

The chief executive weekly meeting had a rolling agenda with some agenda items being standing items to ensure specific issues were considered weekly. An emergency access target remedial action plan had been created and was reviewed weekly. Named individuals were held to account by the chief executive to ensure key actions were delivered. Where actions had not been concluded, the chief executive set clear timescales for completion, as well as considering alternative actions or mitigations which may have been necessary. Although focussed on the emergency access target, the remedial action plan also considered the four local risks thus demonstrating an organisational approach to managing the risks associated with the emergency care pathway.
However, during the inspection we considered a lack of clinical oversight of the adult waiting room presented a risk to patients. Although senior staff were aware of the issue, no remedial action had been taken at the time of the initial inspection to address those risks. We raised this with the trust on conclusion of the inspection. The trust took swift action to address the identified risks, thus mitigating the risk to patient safety.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards.

The local leadership team was able to monitor performance of accident and emergency performance against the four-hour target in real time. Information was shared during bed management meetings which occurred throughout the day.

The emergency department reported to the wider Division B governance meeting. Key quality indicators such as the emergency access target, workforce expenditure, incidents, risks and complaints were all reviewed and scrutinised before being discussed at executive level.

High quality data packs were prepared on a monthly basis which enabled the local leadership team to identify trends against specific themes including but not limited to falls, health and safety incidents and complaints.

**Engagement**

The service positively encouraged the participation and engagement of both staff and patients in planning and delivering services across the emergency care pathway. The voices or patients and staff were captured, considered, and used to make improvements to services.

The design and development of the recently opened children’s emergency department was done in conjunction with existing service users. Lead clinicians facilitated a number of child and young person focus groups during which the views of young people were captured to ensure the department was as user friendly as possible.

The department worked in partnership with schools who were supported to bring children to the emergency department for insight tours. This enabled children and young people to develop an appreciation of receiving hospital care, as well as supporting children and young people who may have developed anxieties of attending the hospital setting.

Alongside the adverse event reporting process, the trust operated a favourable event reporting system. This allowed staff and visitors to report favourable events such as when team working or inter-professional referrals had benefited patients. The local leadership team reviewed all favourable events and fed-back to individual staff members. Staff told us they appreciated this process as it enabled colleagues from across the trust to report positive events as compared to solely focussing on incidents and times when things had not gone so well.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things go well and when they go wrong.
Staff strived to continually improve the services on offer within the emergency department of Southampton General Hospital. There was a clear motivation from across a range of health professions and grades to improve the quality of the service. Staff were encouraged to adopt formalised quality improvement methodologies to affect change. There were appropriate governance mechanisms in place to ensure any proposed changes were monitored to determine their impact and to ensure patient safety. Staff considered financial implications of service change to ensure the department achieved good value for money.

We saw evidence of service reviews by internal teams as well as independent reviews to identify areas of improvement and make the required changes.

The trust was working to expand the unit, relocating and redesigning the waiting area and the resuscitation bay to ensure they were fit for the future. Careful consideration was given to operational demands versus service developments with senior executives supporting the pause of the resuscitation bay redesign until winter pressure periods were seen.

The service had a history of thinking innovatively, especially in relation to multidisciplinary team working in the emergency department. The development of different professional roles and the integration of different health professionals including advanced care practitioners, advanced nurse practitioners and senior support workers were all reported to have positive impacts on quality and patient experienced.

Collaborative work with the local clinical commissioning group was ongoing to ensure staff were aware of, and could access support services external to the organisation.
Medical care (including older people’s care) (Southampton General Hospital)

Facts and data about this service

The medical care core service at University Hospital Southampton NHS Foundation Trust provides care and treatment in 24 inpatient areas as described below:

- Endoscopy unit
- Acute medical unit (54 beds)
- Five elderly wards
- Three respiratory wards including a high dependency ward
- Two gastroenterology wards/ general medicine wards
- General medical ward
- Transition ward
- Three cardiology wards including a Coronary Care Unit (CCU) and high dependency CCU
- Two stroke wards including a hyperacute stroke and neurological day case ward
- Four oncology wards
- Two isolation wards

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 55,295 medical admissions from July 2017 to June 2018. Emergency admissions accounted for 24,001 (43.4 %), 3,190 (5.8%) were elective, and the remaining 28,104 (50.8%) were day case.

Admissions for the top three medical specialties were:
- General medicine
- Clinical haematology
- Cardiology

(Source: Hospital Episode Statistics)

Provision of clinical services at the Southampton General Hospital were structured within four divisions, namely A, B, C and D. Most medical services and older people’s care were a part of division B. Oncology was provided within division A and stroke services within division D. There was a 47-bedded acute medical unit (AMU), a five bedded GP AMU, and an ambulatory care unit (ACU). All these services were provided at Southampton General Hospital.

The following was a general overview: stroke unit (F8 ward), elderly care and dementia wards (G5, G6, G7, G8 and G9 wards), general and speciality medicine wards (D5, D6, D7 and D8 wards), isolation wards (C5 and D10 wards), coronary care unit (CCU) and the cardiac short stay ward.

During this inspection, we visited all the wards, the acute medical unit (AMU), a five bedded GP AMU, the ambulatory care unit (ACU) and the endoscopy suite. We spoke with 45 members of staff including service leads, doctors, nursing staff, healthcare assistants, housekeeping staff, porter’s and administrative staff. We also spoke with 14 patients and three sets of relatives.

We reviewed 41 sets of medical records and looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the trust.
Following a comprehensive inspection in 2015, the trust was required to ensure the following actions were completed:

- The requirements of single sex accommodation are met in the acute medical unit and the cardiac short stay ward, and any breaches are monitored and reported.
- Information leaflets and signs are available in other languages, in plain English and in easy-to-read formats.
- There are robust processes in place to meet the trust's allocated discharge times.
- There is dedicated time for staff to attend essential meetings, such as governance meetings.

**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 completed most of the training. However, the trust did not accurately record doctors’ completion of the relevant mandatory training.*

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. Ward staff and senior nurses told us it had been difficult to release staff to attend training over the winter due to work pressures and shortages of staff. However, the trust ensured there was sufficient support so staff training was not compromised. Support included more frequent training sessions and more on-line 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 had been identified.

A full annual calendar of mandatory training sessions was also in place as it gave staff options to book the training sessions in advance. This enabled planning with additional capacity so staff could book in advance. Trainers also offered to visit larger departments and train staff on site. Trainers also used and used a range of training methods such as workbooks with assessments and scenario based activity sessions, which staff may find easier to access.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training. In medicine, qualified nursing staff, eligible for training, met the 85% target for completion for nine of the 10 mandatory training modules. In medicine, medical staff, eligible for training, met the 85% target for completion for two of the nine mandatory training modules.
At inspection, we found the leadership team had identified *accurate recording of doctors’ completion of the relevant mandatory courses as the main reason for this target not been met.* There was a revived impetus by the clinical lead of division B to ensure both nursing and medical staff completed the necessary training and the recording of completion were accurate. They had started a process of closer monitoring, while recognising their internal bar of 85% was higher than set by some other trusts. Doctors told us their training time had been increased to allow them to catch up on mandatory training. Arrangements were also in place for both nursing and medical staff to attend training days in other specialties to complete mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses from September 2017 to September 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Incident Planning</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>659</td>
<td>684</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>655</td>
<td>684</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>653</td>
<td>684</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>634</td>
<td>684</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>627</td>
<td>683</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>607</td>
<td>682</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>599</td>
<td>684</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>432</td>
<td>510</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>564</td>
<td>684</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for mandatory training courses from September 2017 to September 2018 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>342</td>
<td>351</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>319</td>
<td>351</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>295</td>
<td>351</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>271</td>
<td>351</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>269</td>
<td>351</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>262</td>
<td>351</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>256</td>
<td>351</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>226</td>
<td>351</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>43</td>
<td>72</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Southampton General Hospital medicine department**

A breakdown of compliance for mandatory training courses from September 2017 to September 2018 at trust level for medical staff in medicine is shown below:
2018 for qualified nursing staff in the medicine department at Southampton General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Hygiene</td>
<td>636</td>
<td>660</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>632</td>
<td>660</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>629</td>
<td>660</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>612</td>
<td>660</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>605</td>
<td>659</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>584</td>
<td>658</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>577</td>
<td>660</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>422</td>
<td>497</td>
<td>85%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>542</td>
<td>660</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Southampton General Hospital medicine department, the 85% target was met for seven of the nine mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018 for medical staff in the medicine department at Southampton General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>280</td>
<td>287</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>256</td>
<td>287</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>235</td>
<td>287</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>217</td>
<td>287</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>214</td>
<td>287</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>212</td>
<td>287</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>207</td>
<td>287</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>182</td>
<td>287</td>
<td>63%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>43</td>
<td>72</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Southampton General Hospital medicine department, the 85% target was met for two of the nine mandatory training modules for which medical staff were eligible.

The tables above include staff who work across both Southampton General and Lymington New Forest Hospital.

**Royal South Hants Hospital medicine department**

A breakdown of compliance for mandatory training courses September 2017 to September 2018 for qualified nursing staff in the medicine department at Royal South Hants Hospital is shown below:
## Name of course | Staff trained (YTD) | Eligible staff (YTD) | Completion rate | Trust Target | Met (Yes/No)
--- | --- | --- | --- | --- | ---
Infection Prevention (Level 2) | 15 | 15 | 100% | 85% | Yes
Health and Safety (Slips, Trips and Falls) | 15 | 15 | 100% | 85% | Yes
Corporate Induction | 15 | 15 | 100% | 85% | Yes
Moving and Handling | 15 | 15 | 100% | 85% | Yes
Equality and Diversity | 15 | 15 | 100% | 85% | Yes
Hand Hygiene | 15 | 15 | 100% | 85% | Yes
Local Induction | 15 | 15 | 100% | 85% | Yes
Adult Basic Life Support | 14 | 15 | 93% | 85% | Yes
Manual Handling – People | 10 | 13 | 77% | 85% | No

At Royal South Hants Hospital medicine department, the 85% target was met for eight of the nine mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018 for medical staff in the medicine department at Royal South Hants Hospital is shown below:

## Name of course | Staff trained (YTD) | Eligible staff (YTD) | Completion rate | Trust Target | Met (Yes/No)
--- | --- | --- | --- | --- | ---
Hand Hygiene | 22 | 23 | 96% | 85% | Yes
Corporate Induction | 22 | 23 | 96% | 85% | Yes
Local Induction | 20 | 23 | 87% | 85% | Yes
Health and Safety (Slips, Trips and Falls) | 20 | 23 | 87% | 85% | Yes
Moving and Handling | 19 | 23 | 83% | 85% | No
Equality and Diversity | 19 | 23 | 83% | 85% | No
Adult Basic Life Support | 17 | 23 | 74% | 85% | No
Infection Prevention (Level 2) | 15 | 23 | 65% | 85% | No

At Royal South Hants Hospital medicine department, the 85% target was met for four of the eight mandatory training modules for which medical staff were eligible.

### Princess Anne Hospital medicine department

A breakdown of compliance for mandatory training courses September 2017 to September 2018 for qualified nursing staff in the medicine department at Princess Anne Hospital is shown below:

## Name of course | Staff trained (YTD) | Eligible staff (YTD) | Completion rate | Trust Target | Met (Yes/No)
--- | --- | --- | --- | --- | ---
Health and Safety (Slips, Trips and Falls) | 8 | 8 | 100% | 85% | Yes
Infection Prevention (Level 2) | 7 | 8 | 88% | 85% | Yes
Adult Basic Life Support | 7 | 8 | 88% | 85% | Yes
Corporate Induction | 7 | 8 | 88% | 85% | Yes
Moving and Handling | 7 | 8 | 88% | 85% | Yes
Equality and Diversity | 7 | 8 | 88% | 85% | Yes
At Princess Anne Hospital medicine department, the 85% target was met for seven of the eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018 for medical staff in the medicine department at Princess Anne Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>4</td>
<td>10</td>
<td>40%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Princess Anne Hospital medicine department, the 85% target was met for four of the eight mandatory training modules for which medical staff were eligible.

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

The trust had a policy for sepsis management and staff were aware of it. Staff told us sepsis management training was part of adult basic life support training. The training included the use of sepsis screening tools and the use of sepsis care bundle. We found the training programme on sepsis management was comprehensive. Staff told us they also discussed sepsis management in their team meetings.

Staff received regular training on the potential needs of people with mental health conditions, autism and dementia. They had access to dementia, learning disability and autism specialist nurses. The specialist nurses had visited all wards and met with most staff at their staff meetings. Staff told us most wards had received some level of training. Many staff had accessed a training programme on the potential needs of people with learning disability.

For staff who cared renal patients, the trust had developed standard operating procedures to minimise the risk of infection, electrolyte imbalance, symptomatic dialysis-related hypotension and accidental venous needle/line disconnection. The matron who oversaw the renal service confirmed all dialysis staff had received a contemporaneous training record. We spoke with two renal staff who confirmed they had received a contemporaneous training record.

**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.
Most nursing staff had completed their adult and children’s safeguarding training. Some medical staff had not completed their adult and children’s safeguarding training. The trust had a plan in place to ensure staff had completed their training by 31 March 2019.

The trust had a policy and procedure in place to safeguard children and vulnerable adults at risk of abuse which had been reviewed and was up to date. Nursing staff showed how they located the policies on the trust’s intranet system.

All the staff we spoke with knew how to raise a safeguarding issue or concern. Staff said they completed an electronic incident form and informed the nurse in charge or the ward sister. All staff were aware of who the trust’s safeguarding lead was and how to contact them. There were relevant contact numbers for staff to call if they had concerns about a child’s welfare and/or wellbeing.

In the AMU, we saw one example of staff undertaking additional observation and support for a patient who was having thoughts of self-harm. There were procedures in place around safe restraint and/or rapid tranquilisation if needed.

Staff had good awareness of female genital mutilation (FGM). FGM comprises all procedures involved with partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Staff confirmed FGM was included in their induction training.

The adult safeguarding team had attended a training session provided by the local police on trafficking and modern-day slavery. This was incorporated within the level 3 safeguarding programme.

Most staff were aware of the Mental Health Act S5(2) doctor’s holding power and S5(4) nurse’s holding power. Most staff knew when and how they got urgent advice on this. There were policies and procedures in place for extra observation, supervision and restraint. Staff awareness of vulnerable adults was high and there was a specialist team (the vulnerable adults support team, VAST) working between the department and the local community.

There was also a dedicated safeguarding nurse for young people aged from 16-24 years. In the 10 care records for this specific age group, there were mental state examinations and risk assessments for patients with suicidal thoughts or thoughts of self-harm. The records showed patient’s mental health and safeguarding needs were appropriately assessed, and action taken for onward referral/care where appropriate.

### 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 September 2017 to September 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>31</td>
<td>31</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>620</td>
<td>684</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In medicine the 85% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>536</td>
<td>635</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 85% target was met for one of the three safeguarding training modules for which medical staff were eligible.

Southampton General Hospital medicine department

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018 for qualified nursing staff in the medicine department at Southampton General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>30</td>
<td>30</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>599</td>
<td>660</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Southampton General Hospital medicine department, the 85% target was met for two of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018 for medical staff in the medicine department at Southampton General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>213</td>
<td>287</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>207</td>
<td>282</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Southampton General Hospital medicine department, the 85% target was met for none of the two safeguarding training modules for which medical staff were eligible.

The tables above include staff who work across both Southampton General and Lymington New Forest Hospital.

Royal South Hants Hospital medicine department
A breakdown of compliance for safeguarding training courses September 2017 to September 2018 for qualified nursing staff in the medicine department at Royal South Hants Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>14</td>
<td>15</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Royal South Hants Hospital medicine department, the 85% target was met for three of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018 for medical staff in the medicine department at Royal South Hants Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>12</td>
<td>12</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>17</td>
<td>23</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Royal South Hants Hospital medicine department, the 85% target was met for one of the two safeguarding training modules for which medical staff were eligible.

**Princess Anne Hospital medicine department**

A breakdown of compliance for safeguarding training courses September 2017 to September 2018 for qualified nursing staff in the medicine department at Princess Anne Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Princess Anne Hospital medicine department, the 85% target was met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018 for medical staff in the medicine department at Princess Anne Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>6</td>
<td>10</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Princess Anne Hospital medicine department, the 85% target was met for none of the two
safeguarding training modules for which medical staff were eligible.

University Hospital Southampton (UHS) NHS Foundation Trust recognised all staff had a legal responsibility to prevent harm and reduce the risk of abuse or neglect, pro-actively identify and report concerns.

As well as being accountable to the trust board, UHS safeguarding services were accountable to Southampton City CCG, West Hampshire CCG, Southampton and Hampshire Safeguarding Boards for adult and children.

Safeguarding adults and children merged in October 2017. The appointment of a substantive director of midwifery and consultant midwife for safeguarding children was complete in June 2018 and governance structures had been ratified. These provided clarity of corporate safeguarding team and midwifery safeguarding alignment.

The Safeguarding Governance Steering Group (SGSG) met every other month, chaired by the executive safeguarding lead and director of nursing and organisational development. The safeguarding teams submitted quarterly reports to provide assurance around key performance indicators for safeguarding and mental capacity, as well as updates on the safeguarding agenda. A safeguarding audit/quality assurance plan identified planned audits, the recommendations and actions were presented to the SGSG. The safeguarding children and maternity operational group and quarterly submission of reports to divisional governance forums had been established in line with the new structure.

The trust board had annual safeguarding updates and there was a named non-executive director lead for safeguarding. The safeguarding teams across UHS had monthly team meetings to discuss on-going service improvement and risks and challenges to the service, as well as a weekly/daily huddle to discuss operational updates, consider safeguarding case risks and facilitate work allocation.

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

Cleanliness, infection control and hygiene

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

The trust had up-to-date infection prevention and control policies, which set out the responsibilities of all staff in relation to the prevention and control of healthcare associated infections.

At the last inspection, we found staff did not follow the trust’s infection control policies and hand hygiene procedures. At this inspection we found nursing staff followed the infection control policies and completed infection prevention and control training on a yearly basis to remain up-to-date with policies and national guidance.

There was a revived impetus by the clinical lead of division B to ensure medical staff completed the necessary training. Nursing training rates from September 2017 to September 2018 were 89% with medical staff at 73%. The trust target was 85%. At inspection, we found the leadership team had identified the attendance at mandatory training did not meet the trusts target. They were aware of the poor uptake of training by medical staff and had initiated a process of closer
monitoring while recognising their internal bar of 85% was higher than set by some other trusts. Doctors told us their training time had been increased to allow them to catch up on mandatory training. Arrangements were also in place for medical staff to attend training days in other specialties to complete mandatory training.

All areas we visited were visibly clean and tidy. Equipment was visibly clean and displayed dated “I am clean” stickers which enabled staff to instantly recognise when equipment was last cleaned. We observed housekeeping staff completed various cleaning tasks throughout the course of the inspection and observed the tasks were documented on cleaning schedules. The cleaning schedules were also audited. Patients told us they were happy with the cleanliness of the wards and public areas. We saw staff washed their hands between patient care at all the times.

The Patient Led Assessment of the Care Environment (PLACE) 2018 audit included the cleanliness of the ward. The trust scored about the same as the England average for cleanliness.

### Results of PLACE audit for trust

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>98.4</td>
</tr>
<tr>
<td>England average</td>
<td>98.5</td>
</tr>
</tbody>
</table>

Ward managers were aware of the infection rates on their wards and staff told us they had regular links with the infection control team. A few wards, such as E7 (gastroenterology, hepatology, renal and general medicine ward) had achieved full accreditation. Some, including G7, had achieved “partial accreditation.” To help wards achieve full accreditation the trust initiated a matron led mentor programme.

The trust had an up-to-date uniform policy for staff which set out the responsibilities of all staff in relation to maintaining their uniform. Staff had visibly clean uniforms with short sleeves which meant they adhered to best practice guidelines of being bare below the elbows when providing care and treatment to their patients.

Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharp bins. We observed these bins were not overfilled and there were risk assessments in place for needle stick injuries. Spill kits were readily available in each of the sluices we visited which allowed staff to safely collect and dispose of bodily fluids including blood and urine.

Hand hygiene gel was available at the entrance to every ward, along corridors, and at the bottom of each patient’s bed. We saw staff using hand hygiene gels.

We inspected sharps bins on each of the wards we visited and saw staff had not overfilled any of the sharps bins and all were correctly labelled and secured.

The trust ensured each inpatient area had an independent audit of hand hygiene undertaken by an external assessor of hand hygiene once in the financial year between April 2018 and March 2019. This was in addition to self-reported hand hygiene audits and hand hygiene audits undertaken by the infection prevention team. The results were as follows:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Inpatient HH May 18</th>
<th>IP Nurse HH Aug 18</th>
<th>Inpatient HH Nov 18</th>
<th>GOJO HH 18/19</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Staff recorded the insertion of urinary catheters within the patients’ medical notes. The details included the date, responsible clinician and type/size of catheter used. The records also identified the monitoring and removal of urinary catheters.

The Department of Health (DoH) Health Technical Memorandum (HTM) 01-06, provided best practice guidance on the decontamination of endoscopes. We saw the processes adopted at University Hospitals Southampton were in line with Department of Health recommendations which meant there was a clear system in place regarding the tagging and numbering of endoscopes and their traceability.

We observed processes in place which ensured the decontamination of endoscopic equipment was adhered to. The endoscopes were transported directly to a dedicated decontamination area. All scopes had tags on them which included a use by date and time which enabled the scopes to be traceable. Clean endoscopes were placed in sterile trays, transported to a drying unit and then placed in an ultraviolet cupboard and appropriately stored. We saw staff in the decontamination area wore appropriate disposable gowns, face shields and hair nets.

Patients with known communicable infections were treated at the end of endoscopy lists to enable additional time for deep cleaning of the environment prior to the next patient. Equipment was quarantined and kept separate to the departments other equipment to reduce any risks of cross infection. Staff said they liaised with the infection control lead and consultant microbiologist for advice when required. The radiology department had issued guidelines for all radiology on infection control practices needed to be followed when seeing people with suspected communicable diseases. Staff on wards had access to these guidelines.

The trust’s infection prevention and control policies had guidelines in place for staff to follow if their patients had recently been on holiday in high risk of infection regions. Staff said in such cases, they liaised with the infection control team and consultant microbiologist for advice when required.

The trust followed national guidelines on water treatment systems, dialysis water and dialysis fluid quality for haemodialysis and related therapies. The department of renal medicine undertook regular audits for assurances of these guidelines.

There were multiple wards with side rooms available for use when patients had a suspected communicable infection. Patients with communicable infections were identified with posters on the door. Staff and members of the family were requested to wear personal protective equipment or to speak to the nurse prior to entering. During the inspection we observed staff supported families in the use of aprons and gloves.

Terminal cleans were arranged following the discharge of patients with an infection. We saw notices in the dirty utility rooms advised staff what type of cleaning to organise when a patient was discharged.

However, we had concerns regarding the frequency of change of curtains around the patient bed area. Although the trust infection prevention and control policies stated these were changed every six months when asked ward staff were not aware when the curtains were last changed. We observed a few curtains looked dirty but most were visibly clean.
Environment and equipment

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

We inspected the environment and equipment in each of the areas we visited. Ward areas were kept tidy and free from clutter. This meant people were protected from hazards which could cause tripping or falling incidents. We observed the neurological unit was not fully able to meet patient’s needs of privacy as the nursing station was close to patient’s beds. Conversations held at the nursing station could easily be heard by patients.

All wards we inspected were laid out to ensure separate male and female bays, with toilets allocated to each bay.

There had been no mix sex breaches (where male and female patients were nursed in the same bay on a ward) between September 2017 and September 2018.

At the last inspection, we found the cardiac short stay ward and the G8 ward were not suitable environments to promote the safety, privacy and dignity of patients. At this inspection, there had been physical improvements of these wards. For example, wards (Wards G7 and G8) had recently had an upgrade to be more dementia friendly, ward had bright colours and dementia friendly signage. However, we found the stroke unit located in an older building could not be adapted due to planning restrictions.

In F8, staff kept storage cupboards in all nursing bases tidy and well stocked, six intravenous fluid bags were checked and in date and stored within a locked treatment room. Fifteen further disposable items were checked including swabs, syringes, dressings and catheters. All were found to be sealed and in date.

At the last inspection, we found equipment was not regularly tested and maintained. Records of these checks were not kept. At this inspection, we checked 51 pieces of equipment across the medical division. Each item we checked had an in-date service record and had been subject to safety testing.

Processes were in place to track equipment in use and to act on medical device alerts. Equipment alerts were observed on trust’s own peer reviews.

At the last inspection we found there was insufficient basic equipment in all departments and wards did not have timely provision of pressure relieving equipment, beds and cots. At this inspection, staff said there was sufficient equipment to enable patients’ needs to be met. For example, on F8 ward there was a large variety of hoists available for moving and handling patients safely. Staff said equipment such as pressure relieving mattresses and cushions were available from a central equipment stock. Patients assessed as requiring pressure relieving equipment had this in situ and staff told us they did not have issues with obtaining equipment. Additional equipment had been provided on F8 such as speech and language therapy assessment tools and an iPad. There was refurbishment work being undertaken in the relatives’ room and a planned works programme to develop a dementia friendly environment on the ward. New mattresses had been ordered for all wards and these were serviced regularly.

However, how the staff bases on the acute medical units were positioned meant confidential discussions about patients were not always held in private.
The Patient Led Assessment of the Care Environment (PLACE) 2018 audit included the condition and appearance and maintenance. The trust was worse than the England average for condition, appearance and maintenance (the overall environment).

**Results of PLACE audit for trust**

<table>
<thead>
<tr>
<th>Condition, appearance and maintenance</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>90.5</td>
<td>94.3</td>
</tr>
</tbody>
</table>

We checked the resuscitation trolley on six of the wards, all were locked and had evidence of daily checks and red tamper tags in place to ensure the trolleys remained sealed. However, there was no specific check list for the checking of the major bleed trolley in endoscopy. This was highlighted to the nurse in charge.

**Assessing and responding to patient risk**

**Staff had a proactive approach to risk assessments.** They recognised it was their responsibility to anticipate and manage risks to people who used the service. Staff kept clear records and asked for support when necessary.

Patients had comprehensive risk assessments. Risks identified led to clear care plans on how risks would be mitigated and reduced. In addition, patients had additional checks made more frequently to ensure their safety and to reduce identified risks. For example, some patients had checks on their whereabouts and other patients had checks on their food and fluid intake.

We found responses to patients who were deteriorating were swift and appropriate. We reviewed 23 records and found risk assessments were fully completed and used nationally recognised assessment tools. Risk assessments were undertaken for individual patients in relation to venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient’s records and included actions to mitigate the risks identified. There were strategies for minimising the risk of patient falls on AMU and other medical wards. Staff on these wards demonstrated a good understanding of the causes of falls and how to avoid them.

The medical wards and AMU used the national early warning score (NEWS 2). The scoring identified patients at risk of deterioration or needed urgent review. In the AMU, the NEWS 2 scores were shown on electronic white boards for clinicians to take actions if required. There were dedicated escalation forms to ensure doctors were always aware of the status of their patients. The escalation form included sepsis markers and was used for all people who use the service. Patients were reviewed within 30 minutes of arrival. There was an escalation policy for patients with presumed or confirmed sepsis who required immediate review.

Medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected. We reviewed 23 records and found all had the completed NEWS 2 charts. All records we reviewed showed staff had escalated patients appropriately, and repeat observations were taken within the necessary time frames. Nursing staff told us they felt well supported by doctors when a patient’s deterioration was severe and resulted in an emergency.

Patients admitted at night were either seen by the on-call consultant or the next morning by the consultant in charge of their care. There was a hospital wide standardised approach to the
detection of the deteriorating patient. We observed patients with raised NEWS 2 or suspected/confirmed sepsis were escalated appropriately to the ‘hospital at night’ team. All patients with presumed sepsis were started on the sepsis pathway timelines. Antibiotics were started within an hour. The action plans for these patients were discussed at the night handover. Staff across all wards stated medical care service were responsive and supportive to staff.

All urgent and unplanned medical admissions were seen and assessed by the relevant consultant within the London Quality Standards. These standards stated all medical admissions must be seen and assessed by a relevant consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital and assessed by suitably qualified medical practitioner within 30 minutes. The trust set their own standard of 4 hours of admission and within 6 hours of the time of arrival at the hospital. The division undertook daily audits of their own standards. The data reviewed highlighted over 80% of the admissions were seen by the relevant consultant within 2 hours of admission and were always seen by a suitably qualified medical practitioner.

Consultants we spoke with told us they were always involved for people who were considered “high risk” within one hour of arrival. The trust reviewed (August 2018) all ‘high risk’ cases and found consultants were always involved within the one-hour time period. The service had on-site access to levels 2 and 3 critical care.

Early foot risk assessment of diabetic patients reduced the risk of limb amputation. The hospital performed well on this indicator. In the National Diabetes Inpatient Audit (NaDIA), 100% of patients in 2017 with diabetes received a diabetic foot risk assessment within 24 hours of admission and 100% received diabetic foot assessment at some point during their hospital stay.

Risks were scored and recorded, for example on the “acute stroke unit” proforma on ward F8 and on the “acute medical unit” proforma on units one, two and three. All patients had received a dependency assessment, a bed rail assessment, a falls assessment, a PRESS (pressure risk evaluation and skin screening tool) assessment, a MUST assessment, a moving and handling assessment, a mental capacity assessment, a mental state assessment, a pain assessment, an assessment of daily living skills and a physical healthcare assessment.

The endoscopy unit had a policy in place on how to respond in the event of a major bleed. Staff had assessed the risk and responded to ensure patient safety. The policy stated two teams would be bleeped: one for the management of haemorrhage included a nurse and a gastroenterologist and the cardiac arrest team.

In addition, staff used an escalation process, called “SBAR” (situation, background, assessment and recommendation), which clearly detailed steps to be taken to seek advice on the management of a patients’ deterioration of health and wellbeing.

All areas of mental health, physical health and social risks and needs had been identified. Staff confirmed they had access to 24-hour seven day a week, mental health liaison and other specialist mental health support if they were concerned about risks associated with a patient’s mental health. Staff knew how to make urgent referrals. Staff across all wards stated the service was responsive and supportive to staff.

**Nurse staffing**

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

Nursing numbers were assessed using the national safer nursing care tool and NICE guidance there were identified minimum staffing levels. Planned and actual staffing levels were displayed at the entrance of every ward. During our inspection, we observed planned met and actual staffing level. A trust internal audit confirmed planned met actual staffing levels 100% every day since January 2018 on all medical wards.

At the last inspection we found nurse staffing was not consistently at safe levels to meet the needs and support safe care of patients. Wards did not have the required skill mix to ensure patients were adequately supported with competent staff. At this inspection, the nurse staffing was at a safe level and met the needs of patients and supported safe care. The trust used a ‘red flag’ system to identify any risks due to gaps in staffing levels and had three ‘safety huddles’ a day and reviewed staffing levels to ensure staff were deployed appropriately. Staff were often moved to other wards or booked additional bank or agency staff.

Across the directorate we were told nurse staffing had been a problem, especially over the winter 2017 but things were improving. We spoke with matrons and divisional managers who told us they had undertaken a full staffing review and developed new initiatives to improve staffing. These included supporting current unqualified staff to undertake nurse training and looking at new roles within nursing. At the time of inspection two former health care assistants within medicine were completing foundation degrees. Where shortfalls in nursing numbers were identified, wards with a higher staff levels for the number of patients they had, were moved to support on other wards. Only when these staff moves did not create the necessary balance, temporary staff from NHS Professionals (NHSP), or from an agency, were used to ensure there were adequate numbers of registered nurses to meet patients’ needs. Staff on the medical and care of the elderly wards told us they were often requested to attend other wards or AMU, where there were shortages in staffing level. Initially, they found this transfer unsettling, however, there was now a more embedded culture whereby this new way of working was the norm and not the exception.

Staff on the AMU told us where patients required one-to-one care, there were no difficulties in obtaining additional staff.

We reviewed the staffing rotas for 2 weeks for the months of January and February and June 2018 for wards F7, F8 and D6. We found planned nursing staff levels were met on all the weeks reviewed. Staff on the wards told us there were enough nursing staff on the wards and the care for patients was safe. Agency staff told us they were given a good local induction and handover at the beginning of their shift. To maintain continuity in patient care, the ward staff requested to use the same agency staff who had an experience of working on the ward.

Patients told us the staff and the units were busy, but the nursing staff looked after them and they did not have to wait long for help or care. The two nursing handovers we observed were good. There was a thorough discussion of each patient, which included information about their progress and potential concerns.

The trust has reported their staffing numbers below for the period April 2018 to August 2018 for medicine. The trust filled all their planned posts for qualified nursing staff.

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Total</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princess Anne Hospital (PAH)</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Royal South Hants (RSH)</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Southampton General Hospital (SGH)</td>
<td>600</td>
<td>478</td>
</tr>
<tr>
<td>SGH and Lymington Hospital</td>
<td>26</td>
<td>24</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From September 2017 to August 2018, the trust reported a vacancy rate of 18.8% for Southampton General Hospital in medicine. The trust did not provide vacancy rates for nursing at the trusts other sites.

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

**Turnover rates**

From September 2017 to August 2018, the trust reported a turnover rate of 14.8% in medicine:

- Southampton General Hospital and Lymington Hospital medicine department: 15.3%
- Royal South Hants Hospital medicine department: 0.0%
- Princess Anne Hospital medicine department: 0.0%

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

**Sickness rates**

From September 2017 to August 2018, the trust reported a sickness rate of 3.3% in medicine:

- Southampton General Hospital and Lymington Hospital medicine department: 3.4%
- Royal South Hants Hospital medicine department: 0.9%
- Princess Anne Hospital medicine department: 0.4%

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

**Bank and agency staff usage**

From September 2017 to August 2018, the trust reported 6.5% of qualified nursing shifts in medical care were filled by bank staff and 2.7% of shifts were filled by agency staff.

(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 people safe from avoidable harm and to provide the right care and treatment.
Staffing level and skill mix was reviewed to ensure people always received safe care and treatment and staff did not work excessive hours. There was always a consultant trained in General Internal Medicine or Acute Internal Medicine on call for the acute unit and the ambulatory care unit. Consultants told us they could reach the unit within 30 minutes. This was subsequently confirmed by divisional directors.

The trust has reported their staffing numbers below for the period April 2018 to August 2018 for medicine.

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princess Anne Hospital (PAH)</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Royal South Hants (RSH)</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Southampton General Hospital (SGH)</td>
<td>184</td>
<td>185</td>
</tr>
<tr>
<td>SGH and Lymington Hospital</td>
<td>49</td>
<td>46</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From September 2017 to August 2018, the trust reported a vacancy rate of 0.0% for Southampton General Hospital in medicine. The trust did not provide vacancy rates for medical staff at the trusts other sites.

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

**Turnover rates**

From September 2017 to August 2018, the trust reported a turnover rate of 11.3% in medicine:

- Southampton General Hospital and Lymington Hospital medicine department: 11.3%
- Royal South Hants Hospital medicine department: 5.9%
- Princess Anne Hospital medicine department: 19.4%

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

**Sickness rates**

From September 2017 to August 2018, the trust reported a sickness rate of 1.4% in medicine:

- Southampton General Hospital and Lymington Hospital medicine department: 3.4%
- Royal South Hants Hospital medicine department: 4.8%
- Princess Anne Hospital medicine department: 1.5%

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

**Bank and locum staff usage**
From September 2017 to August 2018, the trust reported 3.6% of qualified medical staff shifts in medical care were filled by bank staff and 1.0% of shifts were filled by locum staff.

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

Staffing skill mix

In July 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 352 whole time equivalent staff working in medicine at University Hospital Southampton NHS Foundation 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>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>30%</td>
<td>27%</td>
</tr>
<tr>
<td>Junior*</td>
<td>16%</td>
<td>25%</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 - Medical (01/07/2018 - 31/07/2018))

The trust responded to the draft NICE quality standards “Emergency and acute medical care in over 16s, NICE quality standard.” The clinical director for division B confirmed their recent review (July 2018) of staffing skill mixes and distribution of staff grades met the standard identified in the Quality Standards in the AMU document. The trust showed us the evidence doctors trained in the specialty of General Internal Medicine or Acute Internal Medicine had up-to-date competencies in advanced life support and were always immediately available.

Records

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

We reviewed 41 sets of nursing and medical records and found staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The records we reviewed were legible, signed and dated. The care plans, charts, daily progress notes and evaluations were of a good standard and covered all aspects of physical, mental health
and social needs. Care plan topics included: capacity, communication, moving and handling, eating and drinking, medicine, elimination, dementia, mental state, behaviour, mobility, keeping active, personal hygiene, preferred day time routines, night care and end of life care. On ward F8 the care plans were highly individualised, personalised, holistic and thoughtful. Some examples such as a “mood enhancing” care plan which included the patient’s likes, dislikes and preferences. For example, encouraging a patient’s family to visit, taking the patient out into the garden area, seeing their pet dog regularly and looking over family photos.

The trust audited the medical records of a range of specialties each year. The objective of the audit was to ensure relevance and completeness of information and detail included in all patient’s medical records. The audit undertaken in January 2018 showed nine areas where the trust had made improvement since the last audit. The audit identified four areas of good practice. These were as follows:

1. All pages in the medical notes contained the patient’s name.
2. Notes were filled in chronological order.
3. History sheets were dated.
4. There were no gaps of greater than 2 days in the notes without an entry by a doctor or midwife.

The conclusions of the audit were:

1. There had been substantial improvements in some key, but basic record keeping standards (patient name and identifiers, date and time of entries, chronological filing).
2. Identification of patient location, ward round leads and persons making entries (including deletions and alterations) all continue to require improvement.

However, during our inspection, we found some inconsistencies in leadership on one ward which led to poor record keeping, medicines management and some evidence of low morale. This was fed back to the trust during the inspection.

**Medicines**

**The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.**

At the last inspection we found medicines were not stored securely across the hospital. At this inspection, medicines (including controlled drugs) were stored securely and at the correct temperatures to remain effective. When temperatures went out of range, staff took remedial action. Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly. However, we found on one ward, D5, entries in the controlled drugs register did not comply with trust policy or Safer Management of Controlled Drugs guidance, 2007. For examples, we saw when there was a mistake in the CD register, staff were not correctly recording these. Seven pages had been crossed out with no records of who crossed the page or the date and reason why. Four entries had not been correctly totalled to zero when medicines were transferred out of the ward. Staff told us they were not aware of the trust policy and required additional training.

Staff accessed medicines supplies and advice throughout the day and out of hours. There was a designated pharmacist on AMU Monday to Friday, 9am to 5pm and staff had access to pharmacy services on weekends between 9am and 4pm. Staff on all medical wards had the out of hours...
pharmacy contact details and senior staff accessed the emergency medicines cupboard out of hours.

Pharmacy teams conducted medicines reconciliation. Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use. Pharmacy teams also undertook discharge prescriptions and handled any medicines related concerns. Pharmacists dispensed medicines on AMU which reduced the time people had to wait for their discharge medicines. All wards had appropriate medicines disposal facilities.

A sample of electronic medicines administration records (EMARs) were reviewed and we saw they were completed fully with no missing administrations. Peoples’ allergy status were recorded onto the EMARs.

Patients clinical notes showed antibiotics were reviewed regularly, however there was no standardised way to record this. We did not find any evidence of the misuse of antibiotics, for example, when antibiotics were given longer than needed. Pharmacists carried out antibiotic audits every quarter on a random sample of antibiotic prescriptions and results showed medical wards were prescribing within trust guidance.

We found venous thromboembolism (VTE) risk assessment were not recorded onto the electronic systems as per trust policy, although people were prescribed medicines for thromboprophylaxis. From March to May 2018, the trust did not achieve the 95% target for completion of VTE risk assessments. During our inspection, VTE risk assessments outcomes were flagged as uncompleted on doctors’ work dashboard. For example, on one ward, we reviewed 11 records and we found four people did not have a recorded initial VTE assessment within 24 hours of admission as per the trust policy. Five people did not have a VTE reassessment completed.

Between October to December 2018, the percentage of patients receiving appropriate prophylactic treatment fell to below the 95% target. On the day of inspection, we found 12 out of 34 people on one ward had not had a VTE risk assessment completed. Clinical staff told us the online assessment took time to complete due to poor connectivity. They said the assessment had been completed in practice but not recorded electronically. The trust had identified this as an area of improvement and had been working to implement an alert system.

The trust had identified the absence of prescription for oxygen as another area of improvement. We found on one ward, three people had been administered oxygen but only one person had oxygen prescribed to them.

Medication errors and harm from medicines were recorded and monitored. We saw learning from recent errors. Staff knew about the medicines errors on their wards however these were not always shared across other medical wards. On the day of inspection, we found two wards had experienced the same administration error with the same medicine in the past month. However, the incident and the learning had not been shared across the medical teams.

Incidents/Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers did not always investigate incidents and shared lessons learned with the whole team and the wider service.

Staff recognised incidents and reported them on the providers’ electronic recording system. Incidents and lessons learnt from incidents were shared at the wards’ daily handover meetings, regular team meetings and at the regular reflective practice meetings which took place on every
ward. Staff learnt from incidents. For example, staff on ward F8 developed a patient self-medication assessment form to ensure patients were confident in taking their medicines and had sufficient knowledge about their medicine. This followed several accidental overdoses by patients recently discharged from the ward.

Incidents reviewed during our inspection demonstrated investigations and root cause analysis took place and action plans were developed to reduce the risk of a similar incident reoccurring. For example, there was an incident regarding inappropriate repositioning and the outcome was a pressure ulcer. The incident was investigated using the Serious Incident Framework (2015). The incident was discussed on the ward where the incident took place. It was also discussed at the divisional governance meeting where the decision was made to highlight this incident in the trust’s “high impact actions paper.” This was a monthly newsletter of all incidents where learning needed to be cascaded across the organisation by patient safety nurses.

Mortality and morbidity meetings took place monthly. All deaths were reviewed daily Monday to Fridays. All deaths in the department were reviewed, root causes analysis following incidents were discussed, and any lessons to be learnt were shared.

The trust had robust systems for compliance with patient safety alerts. The alerts were received from the trust’s central source to care group. The patient safety nurses logged these alerts on a database and took a specified action. For example, they informed all the ward managers with instructions. Each ward manager was required to return a proforma detailing the actions they had completed following the alert, and any outcomes for their ward. The patient safety nurse reported the updates and outcomes from these alerts to the care group clinical governance meeting on a quarterly basis. These were then reported to the quarterly divisional governance meetings.

Staff we spoke with were familiar with the concepts of openness and transparency, and could give us examples of how these were actualised when managing safety incidents. Senior staff in the divisional management team were aware of the Duty of Candour (DoC) principles and what the regulations stated. At the last inspection, there was inconsistency in the staff awareness of the requirements of the DoC regulations and staff had yet to receive training or guidance on the Duty of Candour. At this inspection, we found staff had received training on the DoC and they gave us examples of how they had used this guidance in a patient safety incident. The pressure ulcer incident highlighted above was shared with the patient and their relatives and they were offered an apology for this incident. We reviewed this DOC documentation and found it of acceptable standard.

As highlighted previously, staff knew about the medicines errors on their wards. However, these were not always shared across other medical wards. We have previously highlighted how we found two wards had experienced the same administration error with the same medicine in the past month. However, the incident and the learning had not been shared across the medical 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 September 2017 to August 2018, the trust reported one incident, which was surgery/
invasive procedure incident classified as a never event for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 57 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from September 2017 to August 2018.

Of these, the most common types of incident reported were:
- Pressure ulcer meeting SI criteria with 27
- VTE meeting SI criteria with eight
- Treatment delay meeting SI criteria with eight
- Slips/trips/falls meeting SI criteria with five
- Medication incident meeting SI criteria with three
- All other categories with six

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used safety monitoring results well and took appropriate action as result of the findings. Staff collected safety information and managers used this to improve the service. Some staff were not aware of these results. The results from safety monitoring were not shared with 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.

Medical wards used safety monitoring results well. Senior staff collected safety information.
However, we found some staff were aware of these results. Safety thermometer results were not displayed in ward areas as is considered best practice to enable patients and relatives to understand the performance of the ward. The service used information to improve the service and we saw information displayed in the department. The patient safety nurses encouraged staff to look at the information regularly. They held short meetings to look at the information and discussed how results could be maintained and/or improved.

Staff implemented an initiative called, “Baywatch” which meant an extra staff member was always available in the shared bay bedrooms to assist patients. This initiative had seen a reduction in patient falls by 50% in the preceding six months.

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 the trust reported 64 new pressure ulcers, 94 falls with harm and 73 new urinary tract infections in patients with a catheter from September 2017 to September 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at University Hospital Southampton NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Total Pressure ulcers (64)</th>
<th>Total Falls (94)</th>
<th>Total CUTIs (73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pressure ulcers levels 2, 3 and 4</td>
<td>2 Falls with harm levels 3 to 6</td>
<td>3 Catheter acquired urinary tract infection level 3 only</td>
</tr>
</tbody>
</table>

*Source: NHS Digital - Safety Thermometer*
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of this effectiveness. New evidenced-based techniques and technologies were used to support the delivery of high-quality care. Managers assessed staff compliance with guidance and identified areas for improvement.

The trust had a range of policies and procedures based on national guidance and legislation to support delivery of evidence based care. For example, the trust’s adult safeguarding policy 2018 had been developed alongside Hampshire safeguarding procedures and linked with the care act 2014 and Mental Capacity Act 2015. The trust’s adult slips, trips and falls prevention and management 2018 policy was developed in line with guidance issued by National Institute for Health and Care Excellence (NICE) Clinical Guideline 161 and Royal College of Physicians Fall Safe Care Bundle. The Same sex policy 2017 was based upon the Department of Health (2010) NHS Delivering Same Sex Accommodation.

Policies and procedures were easily accessible on the intranet and staff knew where to find them. In addition, ward staff rooms and notice boards had information around evidence based care such as sepsis, oxygen delivery, dementia and deprivation of liberty safeguards (DoLS) and the frail elderly strategy on the notice board.

The trust adapted guidance on quality standards for medical conditions published by NICE. We saw examples of how NICE guidance on the following had been adapted to the trust’s needs: chronic heart failure, chronic kidney disease, diabetes in adults, acute kidney injury and acute upper gastrointestinal bleeding.

The endoscopy service followed the British Society of Gastroenterology guidelines to provide evidenced based care. The service achieved Joint Advisory Group on Endoscopy (JAG) accreditation in June 2018. The accreditation process assessed the endoscopy department’s infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant the endoscopy department operated within national guidance. The renal unit also used renal association guidelines for monitoring patients.

The trust had implemented a sepsis screening and management strategies for patients who triggered for sepsis intervention. These had been re-designed to align with the requirements for NICE and the Commissioning for Quality and Innovation (CQUIN) for 2017/19. CQUIN is a framework which supports improvements in the quality of services and the creation of new, improved patterns of care.

The trust had implemented systems to ensure all people on the AMU were seen and reviewed by a consultant twice a day. The trust had changed the consultant working day to ensure maximum continuity of care in line with NICE guideline 94.

The transfer of people from the acute medical unit to the ward was done effectively. The charts we reviewed showed consultants completed ward rounds at least once every 24 hours, seven days a week. During the ward rounds, actions identified by the consultants for the patient were documented by their medical team. It was then checked by a senior nurse and a matron to ensure those tasks were completed in a timely manner.

Staff told us they used a range of integrated care pathways and protocols to standardise practice and improve outcomes for patients. These included a urinary catheter pathway, guidance on the
prevention of venous thrombo-embolism (blood clots often referred to as VTE), and
dementia/delirium pathway. For example, patient notes we reviewed demonstrated staff undertook
appropriate health screening for patients including falls risk assessment. For older vulnerable
people, staff followed a care pathway inclusive of a comprehensive assessment of their physical,
mental and social needs. Staff told us if they suspected patients to be experiencing depression,
they could access mental health clinicians for guidance or for mental health assessment, if
appropriate.

The trust participated in national benchmarking clinical audits. Each ward’s local audit schedules
were linked to national guidance such as falls prevention and pressure area care with subsequent
action plans at ward and trust level to address issues found.

There were processes in place to manage and protect the rights of people subject to the Mental
Health Act 1983 (MHA). Senior staff understood the holding powers under the MHA section 5(2)
doctors’ holding power and section 5(4) nurse’s holding power. They contacted the psychiatric
liaison team for additional support or guidance.

**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 dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required.*

Where clinically indicated, patient’s nutrition and hydration needs were assessed on admission
using the malnutrition universal screening tool (MUST). This was in line with NICE guidance QS15

For example, on ward F8 a speech and language therapist carried out a detailed assessment on
every patient. We also saw assessments carried out by dieticians. We saw examples of detailed
food and fluid care plans, for example, one patient was losing weight and had a small appetite.
The patient came into hospital significantly malnourished and underweight. The patient was
assessed by dietician and monitored closely by staff. Staff regularly offered drinks, food and
snacks throughout the day. Staff undertook weekly weight readings once the patient was
stabilised.

Wards had protected meal times. Family members were encouraged to attend at mealtimes if the
patient required assistance with eating so they could provide extra support; there were also
volunteers. Medicines were not routinely administered during mealtimes to allow patients time to
eat without interruption. Wards used red trays to help staff identify which patients required a
modified or pureed food. or support with eating. We observed some mealtimes and saw staff
supported and assisted patients with their meals where necessary.

Staff completed fluid balance charts and monitored patients’ fluid intake with referrals to dietitians
if necessary. Patients had jugs of water within reach on their bedside tables. We observed these
were regularly refilled. Intravenous fluids were also prescribed and recorded appropriately.

The Patient Led Assessment of the Care Environment (PLACE) 2018 audit included patient’s food.
The trust was worse than the England average for food.

<table>
<thead>
<tr>
<th></th>
<th>Food %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>83.3</td>
</tr>
<tr>
<td>England average</td>
<td>90.2</td>
</tr>
</tbody>
</table>
The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required.

In the National Diabetes Inpatient Audit (NaDIA), 51.6% of patients with diabetes reported the timings of their meals were always or almost always suitable compared to 37.6% in 2016. In 2017, 50.5% of patients with diabetes reported the choice of their meals was always or almost suitable compared to 37.4% in 2016. This placed the hospital in quartile 1 and measured the quality of diabetes care provided to people with diabetes while they were admitted to hospital. Quartile 1 meant the result was poor as it was in the lowest 25 per cent, whereas in quartile 4 meant the result was outstanding as it was in the highest 25 per cent for the audit year.

**Pain relief**

**The service managed patients’ pain effectively and provided or offered pain relief regularly.**

Pain was risk assessed and recorded using the National Early Warning Score (NEWS) scale and we saw these assessments were completed. We observed staff asked patients if they were in any pain. Staff had access to tools to help assess the level of pain in patients who were non-verbal. Staff said when choosing pain relief for their patients they started with common medicines, moving to more powerful medicines. Commonly used painkillers were prescribed routinely, but if these were not effective, they asked the pain team for advice and additional medicines were prescribed to ensure patients were pain free and comfortable.

The service met the core standards for pain management services (Faculty of Pain Medicine, 2015). We saw patients with acute pain had an individualised pain management plan appropriate to their condition. Pain was assessed during observations and recorded on NEWS 2 charts. The service had access to the pain management team for advice and specialist assessment when required. We looked at a care plan for a patient who was receiving end of life care and we saw the pain protocol being effectively used. Staff on all wards had been trained to deliver effective pain relief and offer end of life care.

Patients were provided with pain relief in a timely manner. Patients we spoke with said they were asked if they were in any pain usually during interactions with staff. We observed staff discussed pain during handovers and concerns were referred to the consultant.

**Patient outcomes**

**Staff were actively engaged in activities to monitor and improve quality and outcomes. The service proactively pursued opportunities in benchmarking and peer reviews and information was used to improve patient care.**

Information about the outcomes of patient’s care and treatment, both physical and mental were routinely collected and monitored. This was done through both local and national audits.

Because of a global social media movement of #EndPJParalysis, highlighted eating well, drinking fluids and being active can help patients, the medicine for older people launched a 70-day challenge in April 2017. As a result, in July 2017, the directorate formally introduced ‘Eat, Drink, Move initiative.’ During the audits patients who were sat out in a chair, and dressed in day clothes were recorded. The nursing staff were asked to provide a rationale if the patient was not out of bed. To monitor progress, audits were completed in January and September 2018. There was
100% increase in patients dressed up for lunch and 27% increase in patients who sat out in a chair next to their bed for lunch. Of all the medical wards, the transitional ward (F7) had the best performance where 93% of patients were dressed up for lunch and 83% of the patients were sat out in a chair next to their bed for lunch.

To reduce the length of stay of patients on the ICU early mobilisation protocol (EMP), the trust introduced a ward based rehabilitation programme led by generic therapy technicians who had both physiotherapy and occupational therapy skills. The outcome of this intervention is highlighted below. Essentially, there was a reduction in both ward and hospital length of stay. There had been the additional benefit of positive patient feedback.

<table>
<thead>
<tr>
<th>Total number of patients</th>
<th>January to March 2016</th>
<th>January to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male: Female</td>
<td>5:7</td>
<td>12:9</td>
</tr>
<tr>
<td>Age</td>
<td>65</td>
<td>58</td>
</tr>
<tr>
<td>Ward length of stay</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>Hospital length of stay</td>
<td>29</td>
<td>26</td>
</tr>
</tbody>
</table>

The service regularly reviewed the effectiveness of care and treatment through local audit and national audit. The service contributed to all audits. Examples included the national lung cancer audit, the stroke audit and national diabetes inpatient audit. There was variable performance in many national audits related to patient safety and treatment. We saw the specialties discussed audit results as part of their local governance and where necessary had action plans to address any developments.

The infection control report from January to March 2018 identified the central line care bundle had remained at or above 96% in eight of the 12 months from April 2017 to March 2018.

The trust found no difference in the likelihood of death for patients admitted over a weekend versus patients admitted during the week. Through specialist analysis of their data, they reviewed all deaths for patients admitted at the weekend versus deaths for patients admitted during the week compared themselves with the national difference.

**UHS HSMR Performance September 2017 – August 2018**

<table>
<thead>
<tr>
<th>Performance</th>
<th>Site</th>
<th>Trust</th>
<th>Peer</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekday</td>
<td>89.3</td>
<td>95.1</td>
<td>97.4</td>
<td></td>
</tr>
<tr>
<td>Weekend</td>
<td>89.3</td>
<td>98.3</td>
<td>103.2</td>
<td></td>
</tr>
</tbody>
</table>

The endoscopy service had maintained its Joint Advisory Group Gastroenterology Society (JAG) accreditation (June 2018). The accreditation was based on the results of audits which were founded on JAG’s quality and safety in endoscopy global rating scale (GRS) (British Society of Gastroenterology Quality and safety indicators for endoscopy, 2009). The GRS audit was divided into four areas which are: clinical quality, patient experience, workforce and training.

The endoscopy unit had adapted the World Health Organisation (WHO) surgical safety checklist. This was used for every patient undergoing an endoscopy procedure. The tool encouraged dialogue within multidisciplinary teams to minimize harm to patients. The checklist was made up of...
three components; the sign in which included confirmation by the patient of their identity, site of surgery and consent; the time out which included confirmation by the staff team of any identified concerns and thirdly time out which includes details of the procedure, recorded and a confirmation all instruments used had been accounted for. We saw evidence of the WHO checklist in use during the inspection with no issues identified.

We saw the endoscopy service had made improvement in the monthly WHO checklist compliance figures from May to July 2018.

**WHO checklist compliance 2018**

<table>
<thead>
<tr>
<th>Month 2108</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>75%</td>
</tr>
<tr>
<td>June</td>
<td>85%</td>
</tr>
<tr>
<td>July</td>
<td>90%</td>
</tr>
</tbody>
</table>

The cardiac catheterisation unit had adapted the World Health Organisation (WHO) surgical safety checklist. This was used for every patient undergoing cardiac catheterization. The tool encouraged dialogue within multidisciplinary teams to minimize harm to patients. The checklist was made up of three components; the sign in which included checks to be performed prior to any interventions; the time out which included confirmation by the staff team of any identified concerns and thirdly time out which includes details of the procedure, recorded and all instruments used had been accounted for. We saw evidence of the WHO checklist in use during the inspection with no issues identified.

We saw the cardiac catheterisation unit had made improvement in the monthly WHO checklist compliance figures from May to July 2018.

**WHO checklist compliance 2018**

<table>
<thead>
<tr>
<th>Month 2108</th>
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<td>80%</td>
</tr>
<tr>
<td>June</td>
<td>90%</td>
</tr>
<tr>
<td>July</td>
<td>95%</td>
</tr>
</tbody>
</table>

The cardiac care unit worked with the AMU and redesign the existing chest pain pathway. As a result, there was a change to the model of care and the service expanded and took more patients not traditionally cared for by cardiology. An audit undertaken highlighted how these patients had better outcomes and their stay in hospital reduced.

The relevant National CQUIN for the trust were:

1. Reducing the impact of serious infections (Antimicrobial resistance and sepsis)
2. Offering advice & guidance
3. Improving staff health & wellbeing. This included improvement of health and wellbeing of NHS staff/ Healthy food for NHS staff, visitors and patients and Improving the uptake of flu vaccinations for front line staff within providers.
4. Preventing ill health by risky behaviours - alcohol & tobacco

The trust had either achieved or were on trajectory to achieve all the above targets.
Relative risk of readmission

Trust level

From June 2017 to May 2018, patients at the trust had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for elective admissions

Elective Admissions – Trust Level

![Elective Admissions Graph]

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

Non-Elective admissions

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

Non-Elective Admissions – Trust Level

![Non-Elective Admissions Graph]

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

From June 2017 to May 2018, patients at Southampton General Hospital had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for elective admissions

Non-Elective admissions

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric 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

Elective Admissions - Southampton General Hospital

Non-Elective Admissions - Southampton General Hospital

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

**Princess Anne Hospital**

From June 2017 to May 2018, patients at Princess Anne Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gynaecological oncology had a lower than expected risk of readmission for elective admissions

**Elective Admissions - Princess Anne Hospital**

![Elective Admissions Chart](image)

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

- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions

**Non-Elective Admissions - Princess Anne Hospital**

![Non-Elective Admissions Chart](image)

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

**University Hospital Southampton NHS Foundation Trust**

From June 2017 to May 2018, patients at University Hospital Southampton NHS Foundation Trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions

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

Transition plan for audits \im\data\CQC\CQC_Records\INTELLIGENCE\Provider Analytics\Acute Intel Mon FT Ass and Data Dev\HQIP Audits\Plans and Planning\20170815 Transition plan.xlsx

**Sentinel Stroke National Audit Programme (SSNAP)**

The Southampton General Hospital took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in latest audit, from April to June 2018. The ratings have remained consistent in the last two quarters.

**Southampton General Hospital**

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Jan-Mar 18</th>
<th>Apr-Jun 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>2) Stroke unit¹</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>8) MDT working</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>9) Standards by discharge</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>10) Discharge processes</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Team-centred SSNAP level (after adjustments)</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Team-centred Total KI level</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>
## Overall scores

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 18</th>
<th>Apr-Jun 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

1 Included in IM reporting, indicator SSNAPD02

(Source: Royal College of Physicians London, SSNAP audit)

### Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 63.3%, which did not meet the audit minimum standard of 90%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.6%. This is within the expected range than expected. The 2017 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 55.7%. This is within the expected range. The 2017 figure was significantly worse than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 68.4%. This is within the expected range. The 2017 figure was not significantly different to than the national level.

The one-year relative survival rate for the trust in 2017 is 37.1%. This is within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

The trust had an action plan in place on how it planned to meet the results of one area where its performance was poor.

1. Proportion of patients seen by cancer specialist.

### National Audit of Inpatient Falls 2017

The crude proportion of patients who had a vision assessment (if applicable) was 70%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.
The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 66%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 68%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust had an action plan in place and the divisional head monitored its implementation.

Chronic Obstructive Pulmonary Disease Audit

The trust achieved best practice tariff status in quarter 3 of 2017. A Best Practice Tariff (BPT) is a national price paid to providers designed to incentivise high quality and cost-effective care. The aim was to reduce unexplained variation in clinical quality and to encourage best practice. Only 42% of the NHS trust in England achieved this.

In quarter one of the Chronic Obstructive Pulmonary Disease Audit 2018 two of the six metrics at Southampton General Hospital met the national standard. These were:

- Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy
- Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission

In the April 2018 to September 2018 report, the trust scored worse than the national aggregate for the following three metrics:

- Percentage of patients seen by a member of the respiratory team within 24hrs of admission
- Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission
- Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file

Additionally, the trust scored better than the national aggregate for the following two metrics:

- Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%)
- Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy
National Dementia Audit

Comparing this hospital to other hospitals in the 2017 report on the National Audit of Dementia, performance was better in no metrics, worse in one metric, and similar in three metrics. In this context, ‘similar’ means the hospital’s performance fell within the middle 50% of results.

Southampton General Hospital was within the middle 50% of hospitals in England and Wales in the following three metrics:

- Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good
- Percentage of staff responding “always” of “most of the time” to the question “Is your ward/ service able to respond to the needs of people with dementia as they arise?”
- Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour may indicate the presence of delirium.

Southampton General Hospital was within the bottom 50% of hospitals in England and Wales in the following metric:

- Multi-disciplinary team involvement in discussion of discharge.

National audit on cardiology (from HQIP)

All hospitals in England who treat heart attack patients submit data to MINAP by hospital site (as opposed to trust). The trust performed the same as the national average on the outcome of percentage of patients with ST segment elevation myocardial infarction (STEMI) receiving primary PCI within 90 minutes of hospital arrival. However, the trust performed poorly when compared to the national average on the outcome of percentage of patients with STEMI receiving primary PCI within 150 minutes of calling for help. The trust board closely monitored an action plans and were proactive in requesting them in advance. An audit for the period January to March 2019 was planned to be undertaken to assess whether there had been any improvement.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>UHS MINAP Jan – Aug 18</th>
<th>National average Jan – Aug 18</th>
<th>UHS 2016-17 MINAP</th>
<th>All units 2016-17 MINAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients with STEMI receiving primary PCI within 90 minutes of hospital arrival (“door-to-balloon time”)</td>
<td>82.81% A</td>
<td>90%</td>
<td>88.76% A</td>
<td>89%</td>
</tr>
<tr>
<td>Percentage of patients with STEMI receiving primary PCI within 150 minutes of calling for help (“call-to-balloon time”)</td>
<td>70.31% R</td>
<td>75% (Target)</td>
<td>80.34% G</td>
<td>72%</td>
</tr>
</tbody>
</table>

National Audit of Seizure Management

The trust performed better than the national average on the following indicators:
- Temperature taken in the ED
- Eyewitness statement taken or sought
- Plantars examined
- ECG performed
- The patient had some neurology input during their attendance, or was referred to a neurologist as an outpatient

The trust performed worse than the national average on the following indicators:

- Patient sent home on at least one anti-epileptic drug

**National Diabetes Inpatient Audit 2017**

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

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

The 2017 National Diabetes Inpatient Audit identified 154 in patients with diabetes at Southampton General Hospital, 90% of patients with diabetes reported they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 3. Performance improved in 2017 compared to 2016 performance. In 2016 76.3%% of patients were satisfied or very satisfied with overall in hospital care and the trust was placed in quartile 1 nationally. This meant the results were in the lowest 25 per cent.

**Participation in UK Renal Registry**

The trust participated in the UK renal registry

**Competent staff**

The service made sure staff were competent for their roles. Most staff had been appraised to review staff’s work performance and held supervision meetings with them, when required, to provide support and monitor the effectiveness of the service.

Nursing and medical staff we observed and spoke with had the skills and experience to deliver effective care and treatment to patients.

To ensure staff were kept up to date with current legislation they completed a statutory training programme which all staff were required to attend. Attendance was monitored at divisional level. Staff spoken with during the inspection confirmed they had completed their statutory training.

Nursing staff had received training to support their role. On F8, ward staff had received an enhanced education programme in stroke management and care. In addition, staff had been trained in clinical competencies in neurological observation, nasogastric tube management, speech and language therapy. Staff on other wards highlighted examples of other training they
had received. For example, training on how to care for patients with a central line (a long thin tube inserted into a vein in the chest), the insertion of a cannula (the insertion of a plastic tube into a vein to allow direct administration of fluids and medicines) and the monitoring of blood glucose levels which included knowledge of hyperglycaemia (high blood sugar level) and hypoglycaemia (low blood sugar level).

The endoscopy unit had designed advanced competencies for staff to complete during their first 12 months in the department. There were specific competencies for Band 3 and 4 healthcare practitioners to carry out airway management. All healthcare assistants were required to complete their competencies. Other competencies were being developed to expand their role.

Staff told us they received a comprehensive induction when they commenced work at the trust. This included a trust wide induction and local induction. The local induction included orientation to the area and local competencies. Staff told us they found the induction helpful. The trust wide induction included areas such as information governance, infection prevention and control and fire safety. Staff were informed of contractual and statutory duty of candour requirements as part of the hospital induction training. Clinical staff were updated annually as part of the statutory and mandatory training programme. Training courses were provided to clinical staff needing to participate in duty of candour discussions and written correspondence as required.

We saw completed induction checklists for each agency staff on the wards we visited which included an orientation to the area and local competencies.

We spoke with four nursing students who were happy with the training opportunities provided within the medical services. Student nurses had a qualified nurse mentor who worked alongside them to ensure essential skills were learnt and safety was maintained. Nursing students had skills booklets and competencies identified in each area.

The psychiatric liaison team, the leads for dementia and learning disability provided support for staff working with these patients. The learning disability and dementia leads provided awareness training to staff working in the hospital. Nursing staff and healthcare assistants (HCAs) described ways in which they managed and cared for patients living with dementia or a learning disability.

The trust set a target of 92% for appraisal. Across medical care, 88.3% of staff received an appraisal. The target for the following group of staff was not met:

1. Support to doctors and nursing staff
2. Qualified nursing and health visiting staff (qualified nurses)
3. Other qualified scientific, therapeutic and technical staff.

At inspection, the clinical leads of division B and D had started the process of closer monitoring to ensure all staff groups identified above received their appraisal.

The National Diabetes Inpatient Audit (NaDIA) 2017 survey highlighted patients reported staff were, or to some extent, able to answer their questions decreased from 69.9% in 2016 to 64.9% in 2017. In 2017, the trust was in quartile 1. This meant the results were in the lowest 25 per cent. However, patients who reported all or most staff looked after them knew enough about diabetes to meet their needs increased from 42% in 2016 to 69.7% in 2017. The trust was in quartile 3. The audit attributes a quartile to each metric which represents how each value compares to the England distribution for the audit year; quartile 1 means the result is in the lowest 25 per cent, whereas quartile 4 means the result is in the highest 25 per cent for the audit year.
Appraisal rates

Trust level

From September 2017 to August 2018, 88.5% of staff within medical care at the trust received an appraisal compared to a trust target of 92%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>63</td>
<td>62</td>
<td>98.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>44</td>
<td>43</td>
<td>97.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>23</td>
<td>22</td>
<td>95.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>413</td>
<td>383</td>
<td>92.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>635</td>
<td>566</td>
<td>89.1%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>759</td>
<td>639</td>
<td>84.2%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>5</td>
<td>4</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

Southampton General Hospital

From September 2017 to August 2018, 88.3% of staff within medical care at the trust received an appraisal compared to a trust target of 92%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>54</td>
<td>53</td>
<td>98.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>44</td>
<td>43</td>
<td>97.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>15</td>
<td>14</td>
<td>93.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>313</td>
<td>289</td>
<td>92.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>618</td>
<td>550</td>
<td>89.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>729</td>
<td>617</td>
<td>84.6%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>5</td>
<td>4</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The table above include staff who work across both Southampton General and Lymington New Forest Hospital.
### Royal South Hants Hospital

From September 2017 to August 2018, 93.2% of staff within medical care at the trust received an appraisal compared to a trust target of 92%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>100</td>
<td>94</td>
<td>94.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>13</td>
<td>12</td>
<td>92.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>16</td>
<td>14</td>
<td>87.5%</td>
<td>No</td>
</tr>
</tbody>
</table>

### Princess Anne Hospital

From September 2017 to August 2018, 82.1% of staff within medical care at the trust received an appraisal compared to a trust target of 92%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>13</td>
<td>8</td>
<td>61.5%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

### Multidisciplinary working

Staff worked collaboratively together as a team to benefit patients. They found innovative ways to deliver more joined-up care to people who used the service. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Multidisciplinary ward and board rounds were well embedded on the medical wards. This supported an effective handover between medical and nursing teams. The staff across all the wards came from various professional backgrounds, including medical, nursing, social work, occupational therapy, physiotherapy, speech and language therapy, dieticians, psychiatry and psychology. Staff were experienced and qualified to undertake their roles to a high standard. Specialist staff were available, for example, an older adults’ practitioner assessed all older adults admitted to the acute medical units.

Care pathways were multi-disciplinary and staff of all disciplines developed and supported each other in the planning and delivering of patient care. Each professional group recorded their assessments in patient’s medical notes and it was therefore easy to access information about the...
outcome of the evaluation and the ongoing care of the patients from each professional’s perspective. Effective multidisciplinary team (MDT) working practices were established and teams worked well together to improve the effectiveness and timeliness of care. Relevant staff teams and services were involved in assessing, planning and delivering patient's care and treatment and worked together to understand and meet the range and complexity of patient’s needs. We observed patient care on medical wards was supported by a variety of teams. This included pharmacists, a pain management team and physiotherapists.

The pharmacy worked well with staff on the medical wards and provided the following services; medicines reconciliation, an assessment of the patient’s own drugs and drug history gathering, the prescribing of discharge medicines to facilitate speedier discharge while providing discharge counselling and advice when required.

We observed good integration between the vulnerable adult’s specialist nurse, safeguarding lead nurse and the dementia nurse specialist who provided support and advice when required. We saw good examples of staff supporting patients with a learning disability to ensure they received parity of care. Staff liaised with patients, their community and the specialist learning disability nurses at the hospital.

In a joined-up initiative, staff worked with other agencies to ensure patients’ needs were met both inside the hospital and in the local community. For example, staff on F8 ward had strong links with the “different strokes, reclaiming lives after stroke” charity which promoted independence and recovering following a stroke. In addition, the “Stroke association” attended the relatives’ clinic on F8 ward. Volunteers with lived experience of a stroke regularly visited the specialist stroke ward and facilitated support groups for patients and their families.

In the National Diabetes Inpatient Audit (NaDIA), 85.7% of patients in 2017 with diabetes admitted with active foot disease were seen by the multi-disciplinary diabetic foot team (MDFT) within 24 hours. This placed the hospital in quartile 4. This meant the result was in the highest 25 per cent for the audit year.

Seven-day services

The medical service provided a seven-day service.

The trust provided a seven-day service. It met all the four key national standards. The delivery of seven-day services across England was a priority for NHS England. This resulted in the trust carrying out a survey of the seven-day service provided. The tables below set out this achievement.

In the most recent national data the trust had the second highest weekend discharge rates in England.
The results of the audit in April 2018 were as follows:

<table>
<thead>
<tr>
<th>Survey</th>
<th>September 2016</th>
<th>March 2017</th>
<th>April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients reviewed by a consultant within 14 hours of admission at hospital</td>
<td>76%</td>
<td>74%</td>
<td>92%</td>
</tr>
</tbody>
</table>

General ward patients should be reviewed by a consultant-delivered ward round at least once every 24 hours, unless it had been determined this would not affect the patient’s care pathway. The results for April 2018 showed 92% compliance during weekdays and 92% compliance at weekends.

Pharmacy offered a dispensary service from 9am to 5:30pm Monday to Friday and 9am to 5:15pm over the weekend and bank holidays.

The on-call pharmacist offered an emergency out of hours service Monday to Friday from 9am to 5:30pm. They also provided an out of hours service from 5:30pm Monday to Friday.

All cardiology patients received a 365-day echo cardiogram service and seven-day consultant. This meant all new patients and those with complex conditions received a consultant review seven day a week including weekends. Other patients were seen if requested by the on-call senior house officer.

The ambulatory medical unit (AMU) provided 24-hour cover seven days a week. The AMU assessed patients for emergency medical problems. The ambulatory care unit operated from 8am to 8pm seven days a week. GPs used this unit to refer patients who they were concerned for and did not need to visit the emergency department.

Therapy staff worked across the service Monday to Friday 8am to 4pm. This included two qualified physiotherapists, three therapy technicians, two occupational therapists. Handover for the weekend was via a paper copy and a file on the shared electronic system. The service provided one technician on Saturday from 8am to 4pm, and one assistant on Sunday for five hours.
Health promotion

Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and as appropriate for individuals.

Staff identified patients who needed extra support. Health promotion information and materials were on display on the wards. Examples included; eating a healthy diet, moderating alcohol intake, increasing physical activity and smoking cessation.

The trust was engaged in the CQUIN to reduce risky behaviours and offered advice to all smokers and those with lower levels of risk associated alcohol consumption. The trust had been working in collaboration with colleagues from public health and providers of support organisations to ensure a smooth referral process was set up and staff made the appropriate referrals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Capacity assessments were carried out when indicated in the care records. A mental capacity toolkit was available to guide staff. Staff were encouraged to assume a patient had capacity and to undertake all practical steps to support patients to make their own decisions. Where patients had capacity for specific decisions, these were listed in care plans and an emphasis was put on patients’ giving their consent before interventions were made. For example, patient X can make decisions for preferences relating to food, drink, getting up and going to bed and personal care however cannot make decisions relating to finance, oral care or medication. We saw six best interest assessments and authorised DoLS. We spoke to various staff about all aspects of the MCA and they were extremely knowledgeable and confident in discussing this. We found both DoLS and best interest forms were completed appropriately.

From September 2017 to September 2018, the trust reported Mental Capacity Act (MCA) training was completed by 83.8% of staff in medicine compared to the trust target of 85%.

The breakdown by site was as follows:

- Southampton General Hospital and Lymington Hospital: 83.5%
- Royal South Hants: 87.4%
- Princess Anne Hospital: 75.0%

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

Is the service caring?
Compassionate care

Staff cared for patients with compassion. Feedback from patients throughout the service confirmed staff treated them well and with kindness. People felt cared for.

We undertook a standard observed framework for inspection (SOFI) which is a tool developed with the University of Bradford’s School of Dementia Studies and used to capture the experiences of people who use services who may not be able to express this for themselves.

We observed a member of staff support an individual on the stroke ward as they ate their lunch. The individual was comfortable the way the member of staff spoke with them. The interaction created a relaxed atmosphere. The individual enjoyed doing the task because the member of staff recognised, supported and took delight in the individual's skills and achievements. The individual was happy and responded to the use of fun and humour about an upcoming special day.

Patients we spoke with on all the wards were highly complimentary about the staff providing their care. Patients told us they got the help they needed. Patients told us they were treated with respect and dignity. They said staff recognised and supported the reality of the patient. Staff recognised the individual as unique and valued them as individuals. Patients told us staff were pleasant and were interested in their wellbeing, including their psychological wellbeing. Staff used nationally recognised assessment tools to ensure patients’ emotional needs were met. For example, the “Stroke aphasic depression questionnaire” was used to detect depressed mood in patients who have had a stroke.

Patients told us staff demonstrated genuine affection, care and concern for them. We observed gentle and supportive interactions between staff and patients. We observed how a nurse comforted and assisted a patient who was confused. They helped them find their wallet. We saw a doctor patiently listened to patients concerns and when they heard about their pain, responded immediately to their need for pain relief.

Feedback from patients who used the service and those who were close to them was continually positive about the way staff treated people. Patients and their relatives gave us examples of how staff went an extra mile to provide care and support that exceeded their expectation. For example, a member of staff had a family member who had suffered from stroke and they found the presence of their pet dog helped improve the mood of their family member. The member of staff suggested this idea and after appropriate health and safety due diligence, the trust registered 18 pets as therapy dogs for both child and adult services. These pets visited the stroke and dementia wards regularly. Family members took photographs of patients and the therapy dogs. These were displayed at patients’ bedside. One family member told us how their grandchild had not liked visiting the ward however, that changed when they visited on the days when the therapy dogs came to the ward. The family member told us how staff ensured patients’ emotional and social needs were seen as being as important as their physical needs.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 12% which was worse than the England average of 25% from September 2017 to August 2018.

Friends and family Test – Response rate between September 2017 to August 2018 by site.
Emotional support

Staff recognised people needed access to and support networks in the community. They provided emotional support to patients to minimise their distress.

Staff accessed the multi denomination chaplaincy team, which included a duty chaplain and an on-call service, to help provide emotional support to patients and minimise their distress. It was supported by a team of volunteers. All non-urgent referrals were responded to on the same or next working day. Patients were asked their spiritual/religious preferences on admission and this information was used to support patients to receive visits from the chaplaincy team if this was their wish. The chaplaincy team visited the wards daily to offer their support and pastoral care. Chapel services were hosted on a weekly basis and a daily prayer meeting. Holy Communion was available for patients who did not wish to attend the Chapel and a Prayer Room was available on the trust premises for people of all faith and of no faith. During inspection we observed the Prayer Room used by staff and patients.

Staff told us the chaplaincy service created a sense of belonging. They attended when called upon and provided emotional support to patients and their families. They radiated a sense of acceptance of all patients. The chaplaincy team ensured patients of all faiths and of no faith were well supported. Their support extended to hospital staff. Staff said this was ‘excellent’ and of immense benefit to patients, their relatives and staff.

We observed a nurse interacting with anxious relatives, finding them chairs, getting down to their level to assist with the menu card, asking their loved one’s preferences and being reassuring and kind.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Staff spent time talking to people, or those close to them.

Patients told us they were kept informed and were involved in decisions about their care.
Patients told us, 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.

The Patient Led Assessment of the Care Environment (PLACE) 2018 audit included privacy, dignity and well-being. The trust was worse than the England average for privacy, dignity and well-being.

<table>
<thead>
<tr>
<th></th>
<th>Privacy, dignity and well-being %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>76.2</td>
</tr>
<tr>
<td>England average</td>
<td>84.2</td>
</tr>
</tbody>
</table>

We saw a member of staff support an individual living with dementia as they attempted to give them their medication. The individual was called by their name. They were comfortable the way staff spoke with them. Staff demonstrated genuine affection, care and concern for the individual. They offered the individual medication they had to take. The individual refused to take the medication. Staff treated the participant as valued and recognised their experience and age. They left the patient. Fifteen minutes later, the member of staff came again and offered the individual the same medication. The individual, once again, refused to take the medication. This time, staff showed an attitude of acceptance of the situation. However, they escalated this appropriately to the ward sister for further action.

Staff assessed the level of support required and provided it. The senior sister on a stroke ward facilitated a weekly relatives’ clinic and covered topics such as, health, hope, emotions, education and stress. Feedback from these meetings led to improvements in practice. For example, doctors spent more time with relatives so they were clearer about treatment plans prior to patient discharge.

One family told us “everyone was kind and included us and its nice long visiting hours so we can help with feeding. The nurses are nice with lots of time for us and for dad.” Another patient said, “my husband gets included in all planning and discussions and can stay with me – some of the staff feel more like friends but with a nurse-patient relationship”.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people.

The service understood the different requirements of the local people it served. The service actioned the needs of local people through the planning, design and delivery of services. Services were planned in a way which ensured flexibility and choice. For example, G7 was designed as an enhanced dementia care ward.

The trust screened all patients over 75yrs and this information was held on their electronic system. There was also an identification butterfly symbol in use for patients with a known diagnosis of dementia. This meant the service had knowledge of each patient and what support staff could provide to meet their individual needs.

The trust had specialist stroke nurses who assisted with the management of patients admitted to the hospital with suspected strokes or transient ischaemic attack (a mini stroke).
The hospital was committed to working very closely with its NHS and social care partner organisations, to prevent unnecessary admissions to hospital, to make best use of its beds, and to discharge patient’s home in a timely way. The trust’s hospital discharge team worked closely with many different professionals, including doctors and nurses, therapists and the community teams such as the rehabilitation team and the stroke team to improve discharge arrangements.

The service was working closely with local social services to facilitate timely and appropriate discharges for those patients requiring complex social care packages in the community.

Planning the delivery of the service was coordinated at daily bed management meetings.

The 47-bedded acute medical unit (AMU) was open 24 hours a day, seven days a week. Staff told us the unit was always busy and had alleviated pressures in the emergency department (ED). The hospital had a five bedded GP AMU unit, which was designed to prevent avoidable inpatient admissions and manage the increasing numbers of patients requiring emergency admission with referrals directly from GPs.

The hospital in 2017, introduced a consultant-led ambulatory care unit (ACU) where patients were admitted via several different routes, including GPs. The unit followed specific ambulatory care pathways for assessment of deep vein thrombosis (DVTs), pulmonary embolism and for intravenous antibiotic treatment, which formed much of their caseload. Staff told us the ACU helped to meet the needs of patients in the community who required medical intervention without the need to be admitted to the hospital.

The care of the elderly consultants worked on a locality based model and there were named consultants for patients belonging to each GP locality. This improved the continuity of inpatient care, and with communication with patients and families, and with other healthcare services in the community. Patients and their relatives told us they found it beneficial, as they saw the same consultant every time and found it was easier to approach consultants should they need any advice.

Meeting people’s individual needs

The service took a proactive approach to understanding the needs and preferences of different groups of people. Care was delivered in a way that met those needs.

There was support available for patients living with dementia or who had a learning disability, and for staff caring for these patient groups. Staff accessed support and advice from a learning disability nurse for individual patients and there were relevant information and tools on the trust intranet.

The nurse specialist at the rheumatology service supported patients with advice, access to rapid access clinics and avoided unnecessary clinic appointments. This proactive approach demonstrated understanding rheumatology patient’s condition could deteriorate quickly and rapid access clinics would meet their individual needs.

We observed patient’s individual needs being met such as an elderly female patient from the Muslim community having a female relative stay overnight with them as it was not culturally appropriate for them to be alone.

Patient passports and “This is me” documents were used which enabled staff to provide individualised care to patients. Patient passports included information about patients’ likes and dislikes, eating and drinking preferences, special requirements and personal information such as
what the patient enjoyed doing in their spare time and information about their family and pets. This document provided individualised information at a glance to guide staff such as patients' mental state, their level of observation and their key risks such as risk of falling.

Patients were assessed for dementia by specialist dementia nurses. Staff accessed specialist dementia nurses who gave expert practical, clinical and emotional support to families of patients living with dementia.

The enhanced care support team provided care to patients in a variety of ways. They provided a variety of activities whether it was just companionship, creative work or some fresh air on the hospital grounds. Both staff and relatives told us this was a forward-thinking service and eased patient distress.

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.

Medication needs were risk assessed for all patients to ensure medications did not enhance drowsiness. For example, if a patient had been walking around all night, they were more likely to sleep in the morning. The medication time was adjusted to suit individual needs.

Staff ensured they avoided ‘covert’ administration of medication. Staff repeatedly went to the patient to ask them to take the medication. Only when all strategies have failed, they risked assessed the individual patient and then covert medication care plan was initiated.

If a patient living with dementia liked to fiddle whilst walking, care plans included how to manage and support the patient and minimise distress to others. If a patient had two falls, a “2 falls MDT in hospital” took place included doctors, nurse and therapists. As a result, patients with a greater risk of a fall were identified earlier and there were early interventions to reduce these falls.

Volunteers who had experienced a stroke ran a patient drop in service and supported patients with their recovery and their families. A volunteer described how their aftercare from the community stroke team, occupational therapy and speech and language therapy and physiotherapy took into account their condition.

Information was available in different languages. Patient information packs were available on wards. Staff worked closely with the “Stroke association” and had, for example, recently developed a Polish pamphlet, that dealt with swallowing problems and problems in thinking and memory. The trust offered face to face and telephone interpreting for spoken languages, translation services (including braille) and British Sign Language interpreters. Staff knew how to access the translation services and we saw posters on display with clear guidance and contact telephone numbers.

A specialist learning disability team carried out assessments and offered advice to staff. The senior sister on G6 ward attended the trust wide learning disability steering group. Accessible information was available in easy read format.

In a national patient’s survey (2017), the trust performed worse on single sex accommodation for not having to share a sleeping area such as a room or bay, with patients of the opposite sex. However, the trust performed better than other trusts on patients’ being asked to give their views about the quality of their care during their hospital stay.

We saw examples of discharge plans for patients with complex needs. For example, an older adult had been admitted to the acute medical unit following an unwitnessed fall at home. Extensive assessments had been carried out, including, activities of daily living, physical functioning, a frailty
assessment, mobility assessment, social history and long-term conditions. Carers had been supporting the patient at home and they had been fully engaged in discharge planning discussions.

There was a single access for mental health referrals available 24 hours a day, seven days each week. We saw examples of discharge plans for patients with mental health needs which included assessment and advice from the specialist mental health team and the trust safeguarding lead.

Access and flow

Patients could access the service when they needed. The service used technology innovatively to ensure people had timely access to treatment, support and care.

Patients accessed the appropriate services when they needed it. At the last inspection, it was routine for medical patients to receive care on surgical or other non-medical wards. Since August 2017, no medical patients had been cared for on surgical or other non-medical wards.

In response to the pressures within the emergency department (ED) the trust created an ambulatory care unit to help divert medical patients from the ED while ensuring acute medical patients were provided with a better directed and streamlined service.

All senior clinical and operational staff had secure access to “just in time” data of potential areas of “over-flow” of patients: be it in the ED or the ACU or the AMU. It also identified “potential hot spots” such as any potential breach of single sex accommodation or a “potential outlier” whereby a medical patient would have to be transferred to a surgical or non-medical ward to receive their care. The technology brought senior clinical and operational staff to make appropriate interventions to ensure patients had timely access to treatment, support and care.

On each ward, a matron and a senior sister from the ward met twice a day to have “Red to Green” meetings. During these meetings they assessed patients who had been reviewed by medical staff in the morning and ensured all referrals and specific tests had been actioned. A follow-up meeting took place mid-afternoon to review progress on what had been actioned and what remained to be actioned. Ward staff told us the “Red to Green” initiative helped the access and flow of patients. It meant trust discharged patients faster and identified any potential blocks as early as possible.

The radiology ultrasound department set up dedicated ambulatory appointments every day for elderly medicine. This meant patients could be referred for an ultrasound on the same day they saw a clinician at a dedicated clinic. It enabled some patients to be discharged whilst awaiting their scans. It helped with patient flow through the hospital and reduced admissions.

The trust further facilitated early discharge by not performing pleural procedures in the patient’s bay on the wards. Pleural procedures involved the removal of air or fluid (including blood and pus) from the pleural cavity. If such procedures took place in the patient’s bay on the wards, there was a risk to patient safety and a greater likelihood of poor patient outcome.

Inpatient therapies referrals had 48 hours as a maximum target to be seen which had been achieved consistently for physiotherapy, occupational therapists and speech and language therapists. Records reviewed identified timely review by therapists.

Discharge processes involved medical staff, staff on the wards, allied health professionals and an integrated discharge team comprising both trust staff and staff from the relevant local authorities. The integrated discharge team provided collaborative working between the trust and health and social care and offered an individualised and focused approach to discharge planning. Senior
ward staff attended regular discharge planning meetings and said they could raise any relevant
issues with the multi-disciplinary team to ensure resolution prior to discharge.

To facilitate good discharge from the emergency assessment units and improve flow to the
appropriate ward, patients were reviewed by a consultant. Patients who required specialist input,
for example with respiratory conditions, were reviewed by specialist consultants once assessed by
the medical nurse practitioner. This “pull-strategy” ensured patients had timely access to
treatment, support and care.

The monthly SSNAP report for September 2018 identified the stroke unit had improved the
number of patients directly admitted within four hours of clock start. This improvement took place
because the emergency department and the stroke unit came together to revise and improve the
pathway. If a patient did not get to the stroke unit within four hours, it was reported as a breach.

**Average length of stay**

**Trust Level**

From July 2017 to June 2018 the average length of stay for medical elective patients at the trust
was 6.2 days, which is similar to the England average of 6.0 days. For medical non-elective
patients, the average length of stay was 7.6 days, which is higher than the England average of
6.3 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in respiratory medicine is lower than the England
  average.

- Average length of stay for elective patients in cardiology is higher than the England average.

- Average length of stay for elective patients in clinical haematology is higher than the England
  average.

**Elective Average Length of Stay – Trust Level**

![Bar chart showing average length of stay](chart)

*Note: Top three specialties for specific trust based on count of activity.*

Average length of stay for non-elective specialties:

- Average length of stay for elective patients in general medicine is similar to the England
  average.
• Average length of stay for elective patients in geriatric medicine is higher than the England average.
• Average length of stay for elective patients in cardiology is similar to the England average.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Southampton General Hospital

From July 2017 to June 2018 the average length of stay for medical elective patients at Southampton General Hospital was 6.4 days, which is higher than England average of 6.0 days. For medical non-elective patients, the average length of stay was 7.6 days, which is higher than England average of 6.3 days.

Average length of stay for elective specialties:

• Average length of stay for elective patients in respiratory medicine is lower than the England average.
• Average length of stay for elective patients in cardiology is higher than the England average.
• Average length of stay for elective patients in clinical haematology is higher than the England average.

Elective Average Length of Stay - Southampton General 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 is similar to the England average.
• Average length of stay for non-elective patients in geriatric medicine is higher than the England average.
• Average length of stay for non-elective patients in cardiology is similar to the England average.

Non-Elective Average Length of Stay - Southampton General Hospital

Note: Top three specialties for specific site based on count of activity.

Princess Anne Hospital

From July 2017 to June 2018 the average length of stay for medical elective patients at Princess Anne Hospital was 3.9 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 10.3 days, which is higher than England average of 6.3 days.

Average length of stay for elective specialties:

• Average length of stay for elective patients in gynaecological oncology is similar to than the England average.

Elective Average Length of Stay - Princess Anne 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 gynaecological oncology is higher than the England average.
• Average length of stay for non-elective patients in general medicine is lower than the England average.
• Average length of stay for non-elective patients in adult cystic fibrosis service is lower than the England average.
Non-Elective Average Length of Stay - Princess Anne Hospital

Note: Top three specialties for specific site based on count of activity.

University Hospital Southampton NHS Foundation Trust

From July 2017 to June 2018 the average length of stay for medical elective patients at University Hospital Southampton NHS Foundation Trust was 0.0 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 1.7 days, which is lower than England average of 6.3 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.

Countess Mountbatten House

From July 2017 to June 2018 the average length of stay for medical elective patients at Countess Mountbatten House was 0.0 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 39.3 days, which is higher than England average of 6.3 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in clinical oncology is higher than the England
• Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
• Average length of stay for non-elective patients in medical oncology is higher than the England average.

Non-Elective Average Length of Stay - Countess Mountbatten House

![Graph showing average length of stay for non-elective patients in different specialties.]

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

Patients could access the service when they needed and there was minimal waiting time for patients to receive their treatment.

From September 2017 to August 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was constantly better than as the England average. The trust performance dropped slightly in August 2018 to 90.9%, however maintained above the England average (90.0%).

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Eight specialties were above the England average for admitted RTT (percentage within 18 weeks).
### Specialty grouping

<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>96.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>99.6%</td>
<td>93.4%</td>
</tr>
<tr>
<td>General medicine</td>
<td>99.2%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>99.2%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>98.5%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>96.4%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>89.0%</td>
<td>81.9%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for admitted RTT (percentage within 18 weeks).

(Source: NHS England)

### Patient moving wards per admission

From September 2017 to August 2018, in Southampton General Hospital 94.6% of patients were not moved once or more. A breakdown of number of ward moves is in the table below:

<table>
<thead>
<tr>
<th>Number of moves</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>6,966</td>
</tr>
<tr>
<td>One</td>
<td>379</td>
</tr>
<tr>
<td>Two</td>
<td>19</td>
</tr>
<tr>
<td>Three</td>
<td>2</td>
</tr>
<tr>
<td>Four or more</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

### Patient moving wards at night

From to September 2017 to August 2018, there were 9,736 patient moving wards at night within medicine.

- Southampton General Hospital: 9,731
- Princess Anne Hospital: 7

(Source: Routine Provider Information Request (RPIR) – Moves at night)

### Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, it did not respond to complaints in a timely manner.
Patients and relatives were aware of how to make a complaint. The hospital website set out how patients or their relatives could raise a concern. The Patient Advice and Liaison service (PALS) were visible at the front of the hospital and leaflets were available on the wards. We saw posters on the wards with information on how to raise concerns via PALS. PALS worked closely with patient affairs and escalated concerns if a complainant wished to make a formal complaint. The patient affairs team were available to go to clinical areas to meet with the complainant at their request.

Staff knew how to handle complaints. Staff told us they tried to deal informally with concerns and to do this promptly to provide a timely resolution to concerns. Informal complaints were logged and tracked as well as formal complaints.

Literature and posters were also displayed within the ward areas, advising patients and their relatives how they could raise a concern or complaint, either formally or informally. Notice boards on a few wards included ‘You said ‘We did’, in response to patient comments.

The trust did not respond to complaints in a timely manner. It took an average 57.3 days to investigate and close complaints. The trust policy stated complaints should be closed within 35 working days.

The medicine division had a complaint lead who took ownership of the investigation and response before it was referred for executive checking and sign off. Learning from complaints took place through various forums at local divisional/directorate level and across the trust. These include divisional governance meetings, newsletters and patient stories to the board. For example, there had been considerable number of falls on the acute stroke unit. Staff on the stroke unit introduced the concept of ‘Baywatch’ for increased observation of patients and with an additional health care assistant on every shift, this had significantly reduced the number of falls.

Relatives on the stroke unit had complained about how they had received very little guidance as carers on how to care for their relative after their stroke. As a result, one senior sister initiated a ‘relative clinic’ once a week. There were plans to involve a stroke consultant as part of this clinic starting January 2019.

**Summary of complaints**

From September 2017 to August 2018 there were 101 complaints about medical care. The trust took an average of 57.3 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 35 working days.

- **Southampton General Hospital**: There were 97 complaints. The following subjects had three or more complaints:
  - Communication with relatives: eight
  - Communication with patient: seven
  - Discharge arrangements (including lack / poor planning): six
  - Delay/ failure to diagnose (including missed fracture): four
  - Inadequate pain management: four
  - Discharge too early: four
  - Attitude of nursing staff/ midwives: three
- **Princess Anne Hospital**: There were three complaints two relating to appointment error and due to Delay/ failure to Diagnose.
• Victoria House: There was one delayed treatment complaint.

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

Number of compliments made to the trust

From September 2017 to August 2018 there were 41 compliments within medicine.

The breakdown by department is shown in the table below:

- Medicine: 12
- Cancer Care: nine
- Ophthalmology: seven
- Cardiovascular: 12
- Trauma and Orthopaedics: one

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

Is the service well-led?

Leadership

The service had managers at nearly all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Leaders at almost all levels demonstrated the high levels of experience, capacity and capability to deliver excellent and sustainable care. The senior leadership team ensured leaders at the divisional level had skills, knowledge and experience. For example, on a weekly basis, the divisional directors held a joint meeting with the medical director and received trust wide updates. Both divisional directors and their respective teams understood the challenges to quality and sustainability and could identify the actions the division needed to take to address them. For example, the clinical director for division B together with their team enabled quality improvement to be embedded across the service. Senior leaders were involved in ensuring, on a day to day basis, there was a safe and effective approach to clinical staffing and patient flow.

We met with the ward managers during the inspection and found they were organised and demonstrated strong and supportive leadership. They had a deep understanding of issues, challenges and priorities of their service. They were knowledgeable about the ward’s performance against the trust priorities and the areas for improvement. When we raised issues with them, they responded to address them immediately.

We saw matrons were visible on the wards. Ward managers said they were supported by the matrons and medical divisional leads. Staff knew how to contact the medical and nursing lead for their area. Staff told us ward managers and matrons were approachable and supportive and offered advice and training.

Staff were aware of the whistleblowing policy. Three wards (G7, G8 and F6) had undertaken a local survey showed over 95% of staff were aware of the whistleblowing policy. The service had appointed a lead for mental health who had appropriate expertise in this area.
Vision and strategy

The service had a vision and strategy for what it wanted to achieve. The supporting objectives and plans were stretching, challenging and innovative. There were workable plans to turn the vision and the strategy into an action plan developed with involvement from staff and patients.

The trust had developed its culture of safety over the last two years. This was a joint vision of the medical director and the director of nursing and organisational development. Together with the trust board, the medical director and the director of nursing and organisational development identified three values would embed a culture of safety. These were as follows:

1. Patients first. This value focused on person centred care.
2. Forward thinking. This value focused on how teams need to always think ahead.
3. Working together. This value focused on the need of excellent team work.

The divisional leads supported by the lead nurse for the division and the general manager, played a pivotal role in delivering this strategy. The medical care divisional leads and consultant leads from various specialties set objectives and plans were innovative in their approach, stretching in their design and challenging in their targets. For example, the team wanted to be in the top 5 hospitals in England who discharged patients during the weekend. This led to an innovative “Red to Green” initiative on every medical ward and in the most recent national data the trust had the second highest weekend discharge rates in England. The team wanted to transform the front door ambulatory pathways, especially care of the elderly pathways. This led to the design of a consultant led ambulatory care unit. The team wanted to transform the patient journey and treat patients in the most appropriate area and specialism. This led to the “pull strategy” whereby medical consultants went to ED and directed patients to the appropriate ward where they had timely access to treatment, support and care. The team made stronger links with community services to ensure appropriate care was provided on discharge, especially for patients with long-term conditions, and for frail elderly patients with complex needs. The service had improved the sustainability of seven day working across the service and ensured patients were cared in areas most suitable to their needs.

The care of the elderly consultants designed a locality based model and there were named consultants for patients belonging to each GP locality. This improved the continuity of inpatient care, and with communication with patients and families, and with other healthcare services in the community.

The divisional leads ensured staff across the service were aware of the three values. Staff on wards shared with us examples of how their work reflected those values. For example, the respiratory centre changed its opening hours to a more flexible timings two day a week based on patient feedback. The CCU worked together with the AMU and the emergency department and changed the model of care. It expanded and took more patients traditionally not cared for by cardiology. This intervention reduced the overall length of stay.

We concluded the trust’s vision was well recognised and owned by staff. Matrons, ward sisters and therapy staff were passionate about improving services for patients, and providing a high-quality service. Staff told us patient engagement led to a better stroke and respiratory services. Individual wards developed local visions or philosophies of care.
Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Both medical and nursing staff on medical wards reported a good culture. Staff felt supported by their colleagues and matrons in their individual areas. They told us they were proud to work within the trust. Staff said their line managers looked after them well. We also observed positive and supportive interactions between matrons and ward managers. Matrons described having an open-door policy where any member of staff could see them privately. This was confirmed by staff who felt they could address any concerns with the matrons and managers.

There was a strong culture for delivering high-quality care. Most staff felt valued and supported to deliver care to the best of their ability. Openness and honesty was encouraged at all levels and most staff said they felt able to discuss and escalate concerns without fear of retribution. There were good systems for performance reviews for staff.

The trust had a freedom to speak up guardian. The role had a dedicated e-mail and telephone number so staff could access the service confidentially. However, most staff we spoke with were unaware of who the freedom to speak up guardian was but knew of their role and said they would go on the trust intranet to obtain their contact details.

All the staff we spoke with talked about an open and transparent culture within the hospital. An example of this was highlighted to the inspection team. The system changes required a flexible workforce willing and able to work in any part of the trust, if they all had the necessary training. However, some ward staff expressed a sense of unfairness when asked to move from their regular ward to support another ward short of staff. As a result, the director of nursing and organisational development sent personal communication to all nursing staff on the expectation of staff living trust values. One of the values of the trust was to ensure the service met patients’ needs and therefore the movement of staff was necessary to ensure the trust lived those values. Senior staff told us as a result, nursing staff accepted this new way of working and the disquiet slowly and steadily withered away.

Most of the staff we spoke with told us they felt respected and valued by their managers, peers and team members. There were cooperative, supportive and appreciative relationships amongst staff and collaborative working took place. We saw all levels of staff worked and supported each other throughout our inspection including doctors, nurses, healthcare assistants and housekeeping staff. Staff we spoke with were passionate about the people they cared for and ten staff members told us they felt proud of the teams they worked within.

A Workforce Race Equality Standards (WRES) 2017/2018 action plan was in place following a race and equality survey last year. Within this plan training around bullying and harassment had been identified and was ongoing for all managers as well as provision for more visible leadership.

Governance

The trust used proactive approaches to review and reflect best practice. They continually improved the quality of the services and safeguarded high standards of care by creating an environment in which excellence in clinical care flourished.

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 medical services with meetings attended by both divisional leads and senior staff.

Managers, matrons and leaders of the service described the systems and processes of accountability within the medicine service. Staff of all levels understood their roles and what they were accountable for. Nursing staff said they attended ward meetings and we saw meeting minutes were available for staff to read in the staff room.

The service had an overall sepsis lead who oversaw the trust’s sepsis management. The lead had provided the divisional clinical governance committee and the trust board with an overall performance of the trust in sepsis management.

The trust used a monthly harm free care dashboard to triangulate quality and safety metrics with workforce indicators which was reported to the clinical outcomes, safety and quality committee (COSQ), a subcommittee of the trust board. The divisional boards monitored and reviewed quality, safety and workforce data and a safe staffing report was reported directly to the trust board.

Senior staff confirmed there was improved governance around the ‘handling’ of incidents which included; improved monitoring and timely management of incidents within the divisions by the divisional risk leads. The circulation of a fortnightly “incident handlers report” confirmed this. Staff also confirmed learning from incidents, complaints, audits and other quality improvement initiatives were communicated to them in a variety of ways such as; handover meetings, quality safety meetings, e-mails and information on the notice board.

All wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them. The medical services had an effective governance structure. The service had quarterly clinical governance meetings where the results from clinical audit, incidents, complaints and patient feedback were shared with staff. Minutes of clinical governance meetings showed patient experience data which was reviewed and monitored.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The divisional leads identified and reviewed the risks for the service, which was evidenced in the divisional risk registers. Risks identified across the medicine service included; prescribing errors in AMU, increased violence and aggression on staff and inability to hear crash buzzers in areas of AMU. We saw risks were included in the agenda of the medicine clinical governance and assurance meeting. For example, the August 2018 meeting minutes identified the addition of four new risks and the closure of four. There was a total of 14 risks identified for the medicine service of which four were high risk, three medium risk and seven low risk.

The nursing leadership team had introduced a trust wide support for individual wards to learn from each other good infection prevention and control measures. Plans were in place to introduce peer review across the trust. This would enable staff to network and share issues and ideas for improved practice and would act as a problem-solving forum.

Managers monitored a range of performance issues including quality and safety indicators, patient experience indicators and staffing and training indicators. Wards were assessed on their performance in relation to a subset of these which were referred to as the harm free care dashboard. This was based on ward audits and key performance indicators.
The audit data below showed how the trust had considerably improved its performance based on the safety thermometer audit.

The trust board also received an annual report on infection control with oversight of performance on antimicrobial stewardship. There were no specific issues identified by the board to be addressed.

The trust board was made aware of arrangements in place in the trust in case of failure of essential utilities. The board was informed of back emergency generators and additional access to mortuary facilities in case of a local emergency.

The board was made aware of the local emergency preparedness resilience policy (EPRR policy) and the business continuity management (BCM) statutory duties and requirements and how they were met by UHS. The policy was underpinned by the trust’s major incident plan and BCM arrangements. These plans and related activity were reviewed in an annual assurance process led by NHS England. The trust worked with partners in the multi-agency local resilience forum (LRF) and health sector local health resilience partnership (LHRP) to ensure it was part of a joined-up planning, response and recovery process.

The service did not participate in any audits related to mental health and emotional well-being. However, matrons and divisional directors told us how through their walkabout on the wards, they were made aware of issues related to emotional well-being in relation to work related stress. They highlighted how through this process they found staff were not as aware of the freedom to speak-up guardian.

**Information management**

The service collected, analysed, managed and used most information well to support all its activities, using secure electronic systems with security safeguards. However, a few nursing and medical paper records were not stored securely.
Medical leaders had a holistic understanding of performance. Information was used to measure improvements. There were clear and effective service performance measures in place, which were monitored at monthly governance meetings.

The service had a wide range of information available to enable managers and service leads to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances.

Nursing and medical paper records for inpatients were not always stored securely. During our visit, hard copy care records were available on a few wards. On the acute medical units, the records were not stored securely and were kept on a trolley in the middle of the wards. This could have compromised patient confidentiality. We raised this concern with the ward managers during the inspection who confirmed they would address the matter at their next safety huddle. We visited the ward the next day and found action had been taken to improve the storage of records.

Audit data was reviewed at divisional meetings. This meant the service was aware of its performance. The medical director and the director of nursing and organisational development had oversight of all specialities within the division and escalated to the trust board appropriately. This enabled decision makers to have the relevant, up to date information to inform decisions being made about the service.

Information technology systems were used effectively to monitor and improve patient care. For example, electronic white boards were used for effective use of beds. The trust had optimally leveraged this technology and improved patient care. There were effective arrangements in place which ensured data such as serious incidents were submitted to external providers as required.

Senior staff members did not routinely collect, analyse or report on any aspect of patients' mental health or emotional wellbeing.

**Engagement**

The service engaged well with patients, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Patient experience feedback was in use on each ward with a view of increasing the number of patients from whom feedback was obtained. Nursing staff spoken with confirmed they had attended meetings where they listened to patient’s views. Senior staff said the views of patients had helped them in the development of the medicine strategy.

All staff within the medical service felt engaged with their senior management and felt their views were reflected in the planning and delivery of services. Staff said they contributed to the annual staff survey and gave examples of improvements made following the staff survey such as improved access to leadership training.

The trust had implemented a senior clinical and operational staff group “app” to give staff better access to information they needed. These included news alerts, links to important information, access to the e-roster, e-mails and major incident alerts.

The care of the elderly consultants designed a locality based model in partnership with patients and families, and with other healthcare services in the community.

The trust held monthly engagement sessions for all staff. These sessions had a different focus every month, such as updates on both human resources policies and on training. The medical divisional clinical director held monthly listening clinics for all the staff, where staff could raise any concerns or share an experience.
Patients were engaged through feedback from surveys, such as the NHS Friends and Family Test, and from complaints and concerns. Divisional governance meetings showed patient experience data was reviewed and monitored. The division held a ‘carers’ café’ and a ‘memory café’ on a weekly basis, which were led by a dementia specialist nurse.

Learning, continuous improvement and innovation

The service fully embedded a systematic approach to improvement and made patient experience pivotal for staff to learn and enhance the performance of the organisation. Staff created new sustainable models of care and shared their work nationally.

Improvement to the patient experience was pivotal for people to learn and enhance the performance of the organisation. The medical service had introduced an enhanced care and observation process called ‘baywatch.’ Baywatch was designed to provide uninterrupted monitoring of vulnerable patients in a dedicated area. The introduction of ‘baywatch’ reduced the number of falls across the medical service. It improved the patient experience because people were willing to learn and enhance organisational performance.

Following a recent incident in June 2018 where a patient received wrong medication due to the absence of a patient wristband and miss-identification, an audit had recently been completed to monitor the use of wristbands across the division. As a result, the wristband policy was updated to bring medical wards in line with surgical wards to ensure patients always wore two wristbands. Staff from the medical wards were willing to learn from their colleagues on the surgical ward. Porters were empowered to lead and deliver the change. They refused to transfer patients unless two wristbands were in place. The results of the latest audit (October 2018) were positive, particularly within AMU. There was now only one ward with 75% compliance.

Staff sought and embedded new models of care. The design of a consultant led ambulatory care unit had improved patient access without crowding the ED. The transformation of the patient journey had ensured patient were treated in the most appropriate area and specialism. This led to the “pull strategy” whereby medical consultants went to ED and directed patients to the appropriate ward where they could access appropriate and timely care. There was a strong record of sharing work nationally. For example, the specialist dementia ward provided a service staff who worked on those wards felt proud of. A national health journal award considered the ward as innovative approach and identified it as first of its kind in England. It had been short-listed for a national award.

The trust launched a specialist emergency assessment unit for older patients. This new frailty unit, based in acute medicine, included a rapid assessment by a team led by consultant geriatricians. This meant clinical expertise was readily available. The five-bed facility currently operated for eight hours a day but was expected to extend to 12 hours a day over the next few months.

The respiratory medicine department introduced a novel contactless test which provided accurate natural breathing pattern measurements. It involved projecting a checkerboard light onto patients’ chests to record movements which were then processed via computer and made into a 3D model – all within five minutes.

A one-stop clinic speeded up access to pain relief and support for cancer patients. The rapid access multidisciplinary palliative assessment and radiotherapy treatment clinic – known as RAMPART. This was aimed specifically at patients with cancer-related bone pain – known as bone metastases. Patients could now access to a range of specialists in a half-day visit which would previously have required multiple appointments over many weeks.
Outpatients (Southampton General Hospital)

Facts and data about this service

The University Hospital Southampton NHS Foundation Trust provides outpatient appointments for adults for a wide range of medical, surgical and ophthalmology specialities. They provide services at the Southampton General Hospital (SGH), Royal South Hants Hospital (RSH), the Princess Anne Hospital and peripheral clinics at Queen Alexandra Hospital, Lymington New Forest Hospital and at the Countess Mountbatten House. However, the majority of adult outpatient clinics are located at the Southampton General Hospital and the Royal South Hants Hospital. Each year this trust facilitates over 900,000 outpatient appointments.

Children’s outpatient services and maternity outpatient services are not reported in this report. They would be reported under the children and young people core service and the maternity core service reports. However, some children were seen in regular outpatient clinics dependent on speciality including Ear, Nose and Throat (ENT) and ophthalmology. Maternity outpatient clinics are located at the Princess Anne maternity Hospital.

The trust is a regional centre for many specialities including cancer care, cystic fibrosis and allergy and immunology.

The trust provides consultant, nurse and allied healthcare professional-led outpatient clinics. Outpatient clinics are mainly coordinated by the Patient Service Centre.

The trust has four Divisions; Division A, Division B, Division C and Division D. The Divisions are further split up into medical speciality Care Groups. Outpatient departments were managed in the Care Group to which the medical speciality belonged.

The Patient Service Centre (PSC) is part of the Trust Headquarters (THQ) and sits in the Chief Operating Officer (COO) Directorate. The PSC is located at the Southampton General Hospital.

Medical specialities were run out of Southampton General Hospital but some specialities held their outpatient clinics at the Royal South Hants Hospital.

During this inspection we visited the Southampton General Hospital and the Royal South Hants Hospital.
We inspected the following outpatient departments at the Southampton General Hospital:
- Ophthalmology
- Chemotherapy
- Oral and Maxillofacial
- Pathology and Phlebotomy
- Dietetics
- Neurology
- Cystic Fibrosis
- Respiratory
Allergy and Immunology  
Medical care  
Cardiovascular thoracic  
Oncology  
Physiotherapy  
Occupational therapy  
Victoria House - Rheumatology and Managed Care  
Patient Service Centre

and the following outpatient departments at the Royal South Hants department:  
Trauma and Orthopaedics  
Dermatology  
ENT

Inspection findings from the outpatient clinics visited at the Southampton General Hospital are reported in this report and inspection findings from the clinics visited at the Royal South Hants Hospital, inspected at the same time, are reported in a different report. All outpatient services are managed and overseen by the surgical and medical specialities of the University Hospital Southampton NHS Foundation trust, therefore much of the information found in the separate SGH and RSH evidence appendixes are interlinked.

During the inspection we spoke with 22 patients and relatives, 88 members of staff including administration staff, managers, doctors, nurses, allied healthcare professionals and healthcare assistants across the two sites. We observed care being provided, looked at patient waiting areas and clinical environments, policies and procedures and information provided by the trust both before and after the inspection.

**Total number of first and follow up appointments compared to England**

The trust had 707,026 first and follow up outpatient appointments from July 2017 to June 2018. The graph below represents how this compares to other trusts.
Number of appointments by site:

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from July 2017 to June 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southampton General Hospital</td>
<td>789,342</td>
</tr>
<tr>
<td>Royal South Hants Hospital</td>
<td>120,049</td>
</tr>
<tr>
<td>Princess Ann Hospital</td>
<td>101,726</td>
</tr>
<tr>
<td>Lymington Hospital (Peripheral Clinic)</td>
<td>24,698</td>
</tr>
<tr>
<td>Queen Alexandra Hospital Peripheral Clinic</td>
<td>14,338</td>
</tr>
<tr>
<td>This Trust</td>
<td>1,088,389</td>
</tr>
<tr>
<td>England</td>
<td>106,661,135</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics - HES Outpatients)

Type of appointments:

The chart below shows the percentage breakdown of the type of outpatient appointments from July 2017 to June 2018. The percentage of these appointments by type can be found in the chart below:
Number of appointments at University Hospital Southampton NHS Foundation Trust from July 2017 to June 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff. Nursing staff compliance with mandatory training courses was equal to or above the trusts compliance rate of 85%. However, medical staff’s compliance with the majority of training courses was low.

Mandatory training was provided in different formats including as part of the induction process for new starters, face to face classroom training and e-learning. Staff told us training was easy to access via ward computers. Nursing and allied health professionals we spoke with said that time was given to them to complete their training.

Staff we spoke with knew how to access mandatory training and explained how the hospital computer system would flag up any outstanding training or updates that were required.

Senior staff explained how they monitored their staff’s mandatory training compliance and would email staff if training was required. This was confirmed by team members we spoke with.

There was no mandatory training in the management/understanding of patients living with mental health conditions, learning disabilities, autism or dementia. This meant that staff were not routinely trained in the awareness of meeting the potential needs of complex patients. Post inspection the Trust told us they had run a learning disability awareness training session for 60 members of staff working at the trust and this included some outpatient clinical staff.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018, at trust level for qualified nursing staff in outpatients is shown below:
In outpatients the 85% target was met for nine of the nine mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018, at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>69</td>
<td>69</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>69</td>
<td>69</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>69</td>
<td>69</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>67</td>
<td>69</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>64</td>
<td>69</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>43</td>
<td>49</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>60</td>
<td>69</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>59</td>
<td>69</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>52</td>
<td>61</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met two of the eight mandatory training modules for which medical staff were eligible.

Southampton General Hospital outpatient departments

A breakdown of compliance for mandatory training courses from September 2017 to September 2018, for qualified nursing staff in the outpatient departments at Southampton General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>54</td>
<td>56</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>53</td>
<td>56</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>42</td>
<td>47</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>49</td>
<td>56</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>47</td>
<td>56</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>47</td>
<td>56</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Southampton General Hospital outpatient departments, the 85% target was met for seven of...
the nine mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from September 2017 to September 2018, for medical staff in the outpatient departments at Southampton General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Induction</td>
<td>7</td>
<td>9</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>6</td>
<td>9</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>5</td>
<td>9</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>9</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>4</td>
<td>9</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>4</td>
<td>9</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Southampton General Hospital outpatient departments the 85% target was met for two of the eight 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. Staff had training on how to recognise and report abuse and they knew how to apply it. However, medical staff compliance with safeguarding training was low.

Clinical staff understood how to recognise and report a safeguarding concern. Staff we spoke with told us they would talk their concern through with another colleague then escalate their concern to the safeguarding lead, matron or nurse in charge.

We saw that information on safeguarding from abuse was displayed in waiting areas. Female genital mutilation (FGM) was included in the Safeguarding training.

The service displayed information in outpatient reception areas on how to request a chaperone. This informed patients that a chaperone of their own gender was available to accompany them during their appointment on request.

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from September 2017 to September 2018, at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>62</td>
<td>69</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>45</td>
<td>57</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
In outpatients the 85% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018, at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>5</td>
<td>9</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>3</td>
<td>9</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for neither of the two safeguarding training modules for which medical staff were eligible.

**Southampton General Hospital outpatient departments**

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018, for qualified nursing staff in the outpatient departments at Southampton General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>49</td>
<td>56</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>36</td>
<td>45</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Southampton General Hospital outpatient departments, the 85% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from September 2017 to September 2018, for medical staff in the outpatient departments at Southampton General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>5</td>
<td>9</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>3</td>
<td>9</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Southampton General Hospital outpatient departments, the 85% target was met for neither of the two safeguarding training modules for which medical staff were eligible.

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

**Cleanliness, infection control and hygiene**

Not all areas of the service controlled infection risk well and there was no consistent approach to infection control and prevention in the outpatient departments

Not all areas of outpatient services were clean. The trust employed an external contractor to clean the premises and we were told by staff that the standard and frequency of cleaning was an issue. During the inspection we saw and were told about areas that were not clean. For example, unclean toilets in the ophthalmology department and phlebotomy clinic unclean chairs in the neurology department, over flowing waste bins, with open bins in the ophthalmology department and dirty floors in the respiratory sleep rooms.
We saw no cleaning schedules displayed in outpatient departments. There was a ‘toilet cleaned regularly sign’ in the ophthalmology department but there was no schedule or staff sign off to evidence this statement. We were told the cleaning of some outpatient departments occurred Monday to Friday between 4pm and 8pm.

We saw staff’s personal property in clinical areas, for example coats and bags in the phlebotomy room in the chemotherapy department and personal property stored in the diagnostic areas of the ophthalmology department. This could increase the risk of infection by increasing the potential spread of disease from person to person and cross contamination.

During the inspection we asked outpatient departments if they carried out local infection control audits and post inspection we asked for data from these audits. From discussions during the inspection and from data provided post inspection we could see some measures were audited, for example clinical cleanliness and hand hygiene. However, there seemed to be no consistent approach to audits in the outpatient departments, with each department auditing different things and using their own paperwork. There was also no consistent timeframe when audits should occur. We saw gaps in the reporting of information. Therefore, we were not assured there was a universal approach in the trust for the monitoring or reporting of infection control and prevention in the outpatient departments.

No information from infection control audits, such as hand hygiene results were displayed in outpatient areas for patients to see. We were told by staff it had been decided to reduce the amount of information displayed in clinical areas. We were told by the trust there was a Trust de-cluttering strategy to reduce the amount of information displayed in clinical areas, with an agreed list of information to be displayed. This included the area’s infection prevention accreditation certificate and the corporate hygiene signs. We did not see this information displayed in the areas we visited.

Chairs in the outpatient departments we visited were covered in wipeable fabric. However, we did observe dusty chair frames and chairs with rips in their seat covering which could present as an infection risk. We saw a chair in the ophthalmology department that was covered with a black bin liner and had a label saying ‘please do not use this chair’. The chair had been reported to the maintenance team three weeks prior and was waiting repair. We observed a similar chair in the neurology department.

During the inspection we asked staff working in the outpatient departments we visited if the trust’s infection control team carried out regular environmental and clinical practice infection control audits. We were told that walkabouts did happen but they were quite ad hoc. Post inspection we asked for information from the trust’s infection control team on environmental infection control audits. From the information provided it was seen the trust infection control team carried out spotlight reviews of environmental and clinical practice standards in clinical areas on a rolling program, with clinical outpatient areas being reviewed every two years. Due to the infrequency of external infection control audits, if infection control problems arose in the outpatient departments, it could take a while to be recognised and acted upon.

All staff we saw in outpatient areas were bare below the elbow in line with trust policy. This was to promote more effective hand hygiene by ensuring hands and wrists are fully exposed to the hand hygiene product and items that can become contaminated during work activities (e.g. long sleeves, jewellery) or have the potential to harbour micro-organisms were removed. Personal protective equipment (PPE), such as gloves and aprons, were available for staff in all areas where it was necessary. We mostly saw staff using PPE appropriately.
Hand sanitiser gel was mostly available in outpatient areas. However, some department such as the Neurology department had a bottle of gel on the reception desk but no dispensers attached to the walls of the clinic.

We saw posters for staff and patients about the important of hand hygiene. However, each department displayed a different poster, this again highlighting the inconsistent approach to infection control. In addition, as part of the Trust’s de-cluttering strategy, which had an agreed list of information that should be displayed in departments, there was an agreed corporate hand hygiene poster that should be displayed.

Equipment we looked at in the outpatient departments was mostly clean and free from dust. We saw the use of ‘I am clean’ stickers throughout the outpatient departments. Equipment was labelled and dated so staff knew the items were clean and ready for use.

Environment and equipment

Outpatient services were provided in designated clinical areas. Not all outpatient services had suitable premises. In general equipment was looked after well.

There was no single outpatient department at the Southampton General hospital. Therefore, outpatient departments were based in different areas of the hospital with some specialties holding their outpatient appointments at the Royal South Hants Hospital.

Most waiting areas in outpatient areas we visited during the inspection had enough seating for patients. However, some outpatient waiting areas were not suitable for the volume of patients attending, for example the ophthalmology, chemotherapy and the neurology departments. During our inspection we saw these areas to be crowded and patients and their relatives having to stand up whilst waiting.

Most departments had seating for bariatric patients. However, we saw limited seating with arms and high backs for the elderly and not all clinics had enough room to accommodate wheelchairs or mobility scooters. Staff in the neurology department told us the fixed bench seating had to be moved previously to get a wheelchair through the corridor. The cardiovascular thoracic department had two ECG couches, one standard and one that could cater for bariatric patients as well as standard patients.

We were told by staff working in the chemotherapy department they now had automatic opening doors to the department and improved accessible toilets. These improvements were paid for by charity funding. We saw accessible toilets throughout the outpatient departments.

The chemotherapy department was having capacity issues and the number of patients was increasing. Due to needing more room for clinics, rooms previously used as quiet rooms or for support services for example, nutritionists, therapies, speech and language therapist, were now no longer available and patients had to be seen in the waiting room which compromised their privacy. The lack of environment capability had been captured on the division’s risk register.

Some outpatient areas, such as the ophthalmology department, and the cardiovascular and thoracic/oncology department had a main waiting area where patients initially sat. They would then be moved to other waiting areas in the department as they progressed through the clinic.
These smaller waiting areas in the cardiovascular/oncology department were not visible by the reception staff and clinical staff were not always in the areas. Therefore, there was a risk if patients had problems they may not be identified immediately. In addition, in the subwait A waiting room there was a blood taking trolley, which contained clinical equipment including needles and tourniquets. These could easily be accessed by patients without staff knowing.

We had concerns with the ophthalmology department. Although the department had thought about the patient flow round the department, to access different areas in the clinic was not easy for patients. The department was a warren of corridors and clinical areas were cluttered. In addition, due to the busy nature of the department, areas were overcrowded by staff and patients. This made access through the clinic difficult for patients with mobility problems, especially if in a wheelchair and not an ideal environment for the patient group seen, usually impaired or infirm patients. The four vision lanes in the department, where patients had their visual acuity tested, were cramped, busy and noisy. The resuscitation equipment was stored in one of the lanes. Not all lanes could fit a chair in them and we observed an elderly patient needing to hold onto the wall during their test.

Children were seen in the ophthalmology department and they had their own waiting area away from the adult patients.

Treatment bays in the chemotherapy unit did not have curtains that could be drawn for privacy. We were told if patients required privacy they could be taken to the day unit or have screens provided. The department had two chairs that could be reclined if required. The unit had made sure there was enough room for friends and family to sit.

In general equipment was looked after well by staff. We found equipment to be generally stored appropriately and neatly. Equipment consumables were in date and electrical equipment we looked at had evidence of electrical safety testing.

We inspected resuscitation equipment in all outpatient areas we visited. We found trolleys were locked and contained anti-tamper tags. We reviewed records and saw that daily checks were completed for the defibrillator and external equipment and weekly checks completed for the equipment in the draws. This showed a consistent and regular approach to safety checks.

Assessing and responding to patient risk

The trust were developing systems and procedures to assess, monitor and manage risks to patients.

Staff could tell us how they would respond if a patient became clinically unwell in an outpatient area. Staff would monitor them, check their vital signs and request emergency assistance from the medical emergency team and we were given examples by staff when this had happened. If a patient required hospital admission following review and treatment by the medical emergency team, transfer was arranged either to a ward or to the accident and emergency department depending on the nature of the patient’s illness.

There was limited use by clinical staff of the national early warning scores (NEWS) in the outpatient departments. NEWS is a chart used to quickly determine the degree of illness of a
patient. It is based on six patient observations, breathing rate, amount of oxygen in the blood, blood pressure, heart rate, level of consciousness and temperature. It used to help recognise a patient whose condition is deteriorating. Even though NEWS was not regularly used we saw evidence that NEWS2, the updated version of NEWS which had recently been endorsed by NHS England and NHS Improvement for use in hospitals in England, was being explained to staff working in outpatients.

There was a clear process in outpatient departments to check the identity of the patient by using name, address and date of birth. We observed staff obtaining this information from patients that attended for appointments both when they checked in at the outpatient reception desks and before procedures occurred.

Not all waiting rooms in the outpatient departments were in sight of staff. This meant if a patient became unwell or needed urgent assistance, there was no one to raise the alarm. In addition, there were no emergency call bells in these waiting rooms.

Emergency equipment was available in the event of emergency. Clinical staff working in outpatients were required to complete mandatory basic life support (BLS) training. However, this mandatory training had not been completed by all members of staff, nursing staff had a 86% compliancy rate (above the trust target of 85%) and medical staff had a 44% compliancy rate.

Reception staff working in the outpatient departments told us that they had not completed basic life support training and was not mandatory for their role. When asked what they would do if they saw a patient become unwell in the waiting room they said they would alert a member of the clinical team.

We were told by staff that the emergency call bell in the plaster room at the Southampton General hospital site was broken and if assistance was required they had to go into the nearby emergency department to raise the alarm. Management were aware of this and we were told it had been added to the risk register.

We were told by staff working in the neurology outpatient department that if the clinical staff required additional assistance with a patient, for example if a patient was fitting or needed more individual care, they would alert clinical staff working in the management team office via panic alarms in the department. However, during our inspection we witnessed a vulnerable patient who needed individual care and additional staff were not called upon. We also observed that emergency buzzers in examination rooms were not easily accessible.

Standards for Invasive Procedures (NatSSIPs) were used in the trust. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs) such as taking biopsies, removing lesions and injections into eyes. However, it was unclear how embedded these procedures were with staff working in the outpatient departments. There had been a NEVER event (never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them) due to LocSSIPs procedures not being followed in July 2018. We reviewed the root cause analysis for this incident, which included a summary of the incident, the root cause and contributory factors and the main recommendations and specific learning required, which included further education of LocsSIPP.

During the inspection we spoke to senior staff working in the care groups, divisions and the patient service centre, and were told there was now closer monitoring of referral to treatment time (RTT) and waiting times for follow up appointments in the outpatient services. This was because delays in appointments had been discovered which had resulted in harm to patients. Weekly and
monthly meetings between operational staff in the specialities and the patient service centre now occurred and changes in how follow up appointments were entered and reviewed on the trust’s patient appointment booking system.

The majority of follow up appointment delays occurred in the ophthalmology department with 2,500 diabetes and 4,500 glaucoma patients being identified in January 2018. The department was currently working its way through seeing these patients in clinic. The service had risk-assessed the patients to ensure those at increased risk were being seen first. In addition, all patients had been written to explaining the delays and the trust had issued a press statement in October 2018. During our inspection we were told that most of the diabetes patient backlog had been seen but there were still much work to do to clear the glaucoma patient backlog.

**Nurse staffing**

**Outpatient services had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

There are no agreed national guidelines as to what constitutes ‘safe’ nurse staffing levels in outpatient departments. Staffing levels and skill mix were planned on the number of clinics and patients attending.

Clinical services in outpatient departments were provided by outpatient nurses, clinical nurse specialists, healthcare assistants and other allied healthcare professionals.

At the time of our inspection in most outpatient departments, nursing staff met the needs of patients. However, we were told by staff working in the neurology department that 50% of the workforce were currently unavailable due to sickness and maternity leave.

We found across outpatient departments bank and agency staff were rarely used.

We were told by staff working in the chemotherapy department that there was a lack of chemotherapy nurses due to recruitment issues. They said this was having an impact on the service they were providing. Shortage of nursing staff meant it was difficult to release staff to undertake supervised practice and complete competency training, caused delays in patients receiving treatment and a lack of time to give patients the support they needed, which in turn affected the patient experience. The lack of trained chemotherapy nurses had been captured on the division’s risk register.

We were told by senior operational staff working in the Division B directorate there were daily huddles by the Division B matrons and staffing problems would be discussed there. If staffing issues couldn’t be dealt with at a divisional level they would be taken to the daily trust-wide staffing meeting. Although we were told this meeting tended to focus on inpatient staffing issues rather than outpatient departments. Nursing staff tended to work in designated outpatient clinics in their specialities. Therefore, it was unlikely nurses would flex to provide cover for staff shortages in other outpatient clinics.

The trust has reported their staffing numbers for outpatients below for the period April 2018 to August 2018.
Vacancy rates

From September 2018 to August 2018, the trust reported no vacancy figures for nursing staff in outpatients.

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

Turnover rates

From September 2018 to August 2018, the trust reported a turnover rate of 8.8% in outpatients. This was lower than the trust target of 12.0%. A site breakdown is shown below:

- Southampton General Hospital: 10.7%

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

Sickness rates

From September 2018 to August 2018, the trust reported a sickness rate of 3.3% in outpatients. This was lower than the trust target of 3.4%. A site breakdown is shown below:

- Southampton General Hospital: 3.5%

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

Bank and agency staff usage

From September 2017 to August 2018, Southampton General Hospital reported a bank and agency usage rate of 0.3% in outpatients.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Medical staffing

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

All medical staff worked and were managed by the division their medical speciality came under. Medical staff tended to cover both inpatient and outpatient activities.

Medical staffing levels and skill mix were planned on the number of clinics running within the outpatient departments on that day.

During the inspection staff reported good levels of consultant cover for outpatient clinics.

The trust has reported their staffing numbers for outpatients below for the period April 2018 to
August 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southampton General Hospital (SGH)</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From September 2018 to August 2018, Southampton General Hospital reported a vacancy rate of 3.0% for in outpatients. The trust did not provide vacancy rates for medical staff at the trusts other sites.

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

**Turnover rates**

From September 2017 to August 2018, South General Hospital reported a turnover rate of 0.0% in outpatients. This was lower than the trust target of 12.0%.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

**Sickness rates**

As at September 2017 to August 2018, Southampton General reported a sickness rate of 0.7% in outpatients. This was lower than the trust target of 3.4%.

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

**Bank and locum staff usage**

From September 2017 to August 2018, the trust reported no bank usage and locum usage in outpatients department.

From September 2017 to August 2018, Southampton General Hospital reported a bank and agency usage rate of 0.3% in outpatients.

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

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to staff providing care. However, records were not always stored securely in all outpatient areas.

A mixture of record management systems were used across outpatients to record patients’ care and treatment. The majority of outpatient services although using both paper and electronic systems were predominately paper light, meaning that electronic documentation was used rather than written notes.

The trust had migrated older patient documentation to the core electronic patient information system, meaning historic key information such as clinic letters, discharge summaries and pathology were also available to clinic staff electronically.
We were told by clinical staff for patient’s first appointments in clinics the full set of notes might be requested from the UHS health records library but for subsequent follow up appointments patient information would be obtained from the electronic computer system.

In the year before the inspection, the trust reported less than 1% of patients seen as outpatients did not have their full medical records available. We were told that if records were not available the medical clinician would be alerted and it would be their decision whether to postpone the appointment.

Following appointments, if there was any paper based patient information, this would be scanned by outpatient staff onto the electronic computer system so patient information was accessible to all clinical staff. Administrative staff in the chemotherapy department told us that paper notes were scanned after clinic. The paper notes would be kept two weeks before they were shredded into the confidential waste bin. Other departments told us that clinic notes once scanned were immediately shredded. It was unknown if there was a trust policy in regard to the shredding of clinical paper notes.

We saw confidential waste was stored securely and disposed of appropriately.

During our inspection we saw that most outpatient departments had secure areas to store patient’s records, for example the neurology and chemotherapy departments were stored behind the reception area. However, we did see paper notes used in clinics were left unattended and computers used to record patient information not locked in clinical areas. Clinical staff we spoke to told us that it was not always ideal where patient notes were kept during clinic but they had tried to mitigate to make sure patient confidentiality was maintained. For example, the cardiothoracic/oncology department had their clinic notes on the corridor outside the consultant rooms. When they had risked assessed this they felt there was usually a clinical staff member present outside the clinic rooms who would notice if notes or computers were tampered with. The ophthalmology department used frosted plastic holders to store patient notes outside the treatment rooms so patient information could not be seen.

We had concerns with the metal racks used to store clinic notes outside the consultant rooms in the neurology department. We felt there could be a potential risk of injury to patients given the cohort of patients seen and the proximity to patient’s head and faces to the racks. Staff did not know if there had been a risk assessment carried out on the metal racks.

Staff in the patient service centre showed us the systems they used to manage appointments, records and collect clinical data. Electronic patient information was only available to authorised people, and computers and computer systems were password protected.

People with a learning disability or a mental health condition were flagged on the electronic patient record. This meant it was easy for staff to see if patients would require additional support whilst in clinic or needed to be scheduled at the beginning of a clinic if possible.

Medicines

Arrangements for managing medicines in the outpatient services were mostly suitable to ensure patients were kept safe from avoidable harm.

We saw most outpatient departments kept a low stock of drugs. Drug cupboards across the outpatient departments were locked with a registered nurse holding the keys. Medicines were
stored securely and at the right temperature to remain effective. All drugs we checked were in
date.

Medication fridges were locked when not in use and checked daily to make sure they were within
the correct temperature range. Fridge temperature records we reviewed confirmed this. When we
asked what would happen if fridges went out of range we were told by clinical staff that they
would contact pharmacy for advice. We were given examples when this had happened and the
actions that had occurred.

Staff we spoke with told us they had good links with the pharmacy department.

We observed chemotherapy medication were bought to the clean utility room in the
chemotherapy department by the specialist pharmacist. This medication was then checked by a
trained registered nurse in the clean room before being taken through to the treatment area in the
chemotherapy suite, where it was checked again by a registered nurse before being administered
to the patient. This double checking of medication was to ensure that the right medication was
received by the right patient.

We had concerns with the area where the medication was initially checked in the clean room. The
clean room was used for a number of reasons by staff and was the main area where the nurse in
charge coordinated the staff and patients. It was a busy area with staff continually entering and
exiting the room. We saw nursing staff checking the chemotherapy medication. However, there
were no processes in place to indicate to other staff that that medicines were being checked and
therefore should not be interrupted. In addition, the activity in the room did not stop whilst drug
checking occurred. Although no incidents of miss-checked drugs had been reported, it would be
easy to become distracted in that environment. Post inspection we asked to see the policy on
prescribing, administration and safe handling of cytotoxic drugs in adult chemotherapy services.
The policy did not include details of the environment needed to check medication safely. The
policy had been issued in August 2011 and expired October 2018. We were told by the trust, the
policy was currently being updated including the safe handling of medication and would be
reissued after January 2019.

In the previous CQC inspection reports April 2015 and June 2017, there had been concerns with
the use of patient group direction (PGD) in the ophthalmology department to cover the supply
and/or administration of eye drops and eye ointments. A PGD allows specified healthcare
professionals to supply and/or administer a medicine directly to a patient with an identified clinical
condition without the need for a prescription or an instruction from a prescriber.

At this inspection, the ophthalmology department PGDs were in use only by Band 5 and above
nurses. We reviewed 10 PGDs and found they were all signed by appropriate staff but required
reviewing August 2018. The sister in charge was aware the review was overdue and had identified
this as a priority. A new standard operating procedure (SOP) for the use of Tropicamide (a
medication used to dilate the pupil of the eye so the eye could be examined) had been written with
advice from the Medicines and Healthcare products Regulatory Agency (MHRA) on the safe use
of Tropicamide. The MHRA are an agency with the responsible for the safe use of medicines and
medical devices in England. The SOP was awaiting sign off by the trust’s pharmacy team before it
could be implemented. This SOP allowed healthcare assistants to administer the eye drops as
long as they had training on medicine management and received an annual competency
assessment. We reviewed training records for five of the healthcare assistants and found they had
up to date medicine training and had read the SOP and two had up to date competency assessments. The SOP also stated that the department needed to carry out twice annual random audits of 25 case notes to ensure standards were maintained. However, there was no evidence of this being carried out.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

No figures were supplied by the trust pre inspection in regard to the number of incidents reported in outpatient departments or the number of times duty of candour had been used in the outpatient departments.

Staff we spoke with in the outpatient departments had a good understanding of what to report as an incident. They all understood their responsibility to raise concerns, felt confident to report them and knew how to use the electronic reporting system. Staff gave examples of incidents they had reported. For example, when a letter was sent to the wrong patient in the physiology outpatient department and transport issues for patients in the rheumatology and oral and maxillofacial outpatient departments. Staff could describe learning from incidents. For example, we were told the trust no longer used window type envelopes for patient letters. This was because a group of letters meant for a GP surgery had been sent to the wrong address due to a different address being visible through the envelope window, and changes in working practices in the ophthalmology department after a laser treatment incident.

We were told by staff that incidents and learning from incidents was disseminated in various ways, for example, through daily huddles and meetings, formal monthly meetings, in newsletters and via email. We saw evidence that incidents were discussed at monthly care group meetings.

The care group to which the speciality belonged managed each outpatient department and feedback from incidents was generally kept within each care group. Therefore, we were unsure that learning from incidents was trust wide.

There was an electronic reporting system to allow staff to report incidents. This included a mandatory field on duty of candour. All staff we spoke with during the inspection were aware of and could explain the meaning of duty of candour.

Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

**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 October 2017 to September 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Although no never events had been reported for outpatients. There had been two never events reported in the ophthalmology department in 2017 and July 2018 where processes where not followed resulting in procedures to the wrong eye. This never events were reported under the surgery core service rather than outpatient services. Staff we spoke with in the ophthalmology outpatient department were aware of learning from these recent never events. For example, better communication between team members irrespective of their grade or role.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 22 serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from October 2017 to September 2018.

- Treatment delay: 19
- Confidential information leak/ information governance breach: one
- Surgical/ invasive procedure: one

(Source: Strategic Executive Information System (STEIS))

We reviewed a sample of the root cause analysis investigations for the serious incidents reported relating to outpatient areas and found that serious incidents were fully investigated in line with trust policy.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Clinical guidelines and policies were developed and reviewed in line with National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies and protocols were available on the hospital’s intranet.

The trust had a clinical effectiveness (CE) team which reviewed the NICE website for updates in guidance. The CE team send this information to specific leads in the medical specialities to complete a gap analysis of their service compared to the new NICE guidance, and to incorporate the necessary changes into their working practices. The clinical effectiveness steering group (CESG) audited to make sure that working practices have been changed to meet current guidance.

Post inspection the trust provided evidence of compliance audits with NICE guidelines in outpatients. We were given details of current audits being taken which included an audit to see if the assessment and management of patients referred to general neurology clinics with headaches were being diagnosed and managed in accordance with NICE guidelines and quality standards.

Nutrition and hydration

Staff ensured patients had enough food and drink during their visit to outpatients.

Water was available in all outpatients waiting areas we visited. Vending machines were situated in some outpatient clinics and at various points round the hospital. The hospital had a selection of places to eat in or purchase food and drink.

There was a hydration station on the chemotherapy unit and we observed clinical staff offering patients drinks throughout their treatment.

Although there was no formal process in place, staff would make sure patients got meals if they had very long delays waiting for their patient transport.

If required, outpatient patients could be referred to the trust’s diabetes or nutrition and dietetics inhouse services.

Pain relief

Patients were not routinely assessed for pain in the outpatient departments, as this was not generally a clinical risk. However, if needed, pain would be discussed by the consultant as part of the presenting condition and captured in the patient notes accordingly.

Clinical staff, if needed, would discuss simple pain medication and its use for patients at home and would give advice when to seek guidance. We saw pain management was discussed with a patient in the chemotherapy suite.
There was an acute pain team in the trust which consisted of acute pain nurse specialists who patients could be referred and advise medical staff on pain relief. However, this service was mainly for inpatients after surgery. Since 2014 there had been no chronic pain management service run at the trust. If patients required this service they would be referred to a chronic pain management service run by another local trust.

**Patient outcomes**

There was limited monitoring of the effectiveness of care and treatment in the outpatient service.

Clinical audits were not routinely carried out within outpatient services. Some specialities had their own audit programmes, for example, the cystic fibrosis department.

The trust run an internal clinical accreditation scheme (CAS). This involved walkarounds in clinical areas to assess certain outcomes, for example, how it appeared, looked, sounded and smelled. The scheme was originally for inpatients areas and had not included outpatient areas. However, outpatient departments were now involved in the CAS and we saw certificates in some of the outpatient departments saying they had reached quality standards. We were told by senior staff working in the outpatient departments, whilst implementing the clinical accreditation scheme, it was found there was no clinical dashboard for outpatients. Therefore, this had needed to be developed before outpatient departments could join the clinical accreditation scheme. We reviewed the outpatient clinical dashboard and saw that information on incidents, patient feedback, complaints, cleanliness and falls were included. However, not all outpatient departments were routinely collecting this information to enter into the dashboard. This meant there was not full oversight of patient outcomes across all specialties.

When we spoke with staff working in the outpatient departments we found they were very proud to now be included in the scheme and celebrated when the department had reached the standards required to get their CAS certificates.

**Follow-up to new rate**

Follow-up to new rate is a measurement of the number of follow-up appointments required after the initial appointment and is recorded as a ratio.

From July 2017 to June 2018,

- From July 2017 to October 2017 and in February 2018 the follow-up to new rate for Lymington Hospital (Peripheral Clinic) was lower than the England average. Lymington Hospital performance was similar to the England average from November 2017 to January 2018 and in May 2018. Lymington Hospital performance was higher than the England average in March 2018 and the latest month; June 2018.
- From July 2017 to January 2018 the follow-up to new rate for Queen Alexandra Hospital Peripheral Clinic was lower than the England average.
- The follow-up to new rate for Royal South Hants Hospital was higher than the England average.
The trust performance was similar to the England average from February 2018 to May 2018. The trust performance dropped below the England average in the latest month; June 2018.

- The follow-up to new rate for Princess Anne Hospital was lower than the England average.
- The follow-up to new rate for Southampton General Hospital was higher than the England average.

Follow-up to new rate, University Hospital Southampton NHS Foundation Trust.

(Source: Hospital Episode Statistics)

Competent staff

The service made sure staff were competent for their role. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor effectiveness of the service.

The trust had an induction programme for newly appointed staff. This included a one-day induction day which included a member of the executive team welcoming new starters to the trust. We spoke with staff who had recently joined the trust and had attended the induction day and were now working their way through the mandatory and statuary training modules required to work at the trust.

We saw that nurses, healthcare assistants and allied health professionals completed competency frameworks to ensure they were competent to carry out their role. There were general competencies and competencies specific to the medical speciality they were working in. We reviewed competency frameworks and found them to be detailed and completed correctly. We were told about extended competencies in many of the outpatient departments.

Staff we spoke with were positive about opportunities for further training with internal development being encouraged by their managers. We were given many examples across the outpatient departments of this, including, clinical development so staff could process to higher bands in the ophthalmology and physiology departments.
We were given many examples by outpatient staff about training opportunities open to them. For example, specialised training days had been attended in the cardiovascular and oncology departments, leadership training in the physiology department, bespoke training on how to deal with abusive patients in the patient service centre and a staff member was being supported to carry out an apprenticeship diploma in the phlebotomy department.

However, some staff told us that although there were training opportunities it was not always easy to take due to their workload pressures and the level of staffing in their departments. We were told by staff in the oncology department that they felt training opportunities had been blocked to them. However, due to a change in management in the department they were now able to go on training courses.

Staff told us clinical supervision, mentoring and coaching was available to them.

Staff we spoke with had yearly appraisals with their managers. The trust appraisal form had recently been updated and was now linked to trust values. We were told by staff there was a clear structure for setting objectives and discussing and identifying training needs. During the inspection most staff could tell us when they last had an appraisal and when their next one was due. Several staff we spoke with had had an appraisal in the last two months.

**Appraisal rates**

From September 2017 to August 2018, 79.0% of staff within the outpatient departments at the trust received an appraisal compared to a trust target of 92.0%.

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>125</td>
<td>111</td>
<td>88.8%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>8</td>
<td>7</td>
<td>87.5%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>18</td>
<td>14</td>
<td>77.8%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>83</td>
<td>60</td>
<td>72.3%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>17</td>
<td>12</td>
<td>70.6%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>37</td>
<td>23</td>
<td>62.2%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Southampton General Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Support to doctors and nursing staff | 65 | 59 | 90.8% | No |
Qualified Allied Health Professionals (Qualified AHPs) | 18 | 14 | 77.8% | No |
Qualified nursing & health visiting staff (Qualified nurses) | 58 | 42 | 72.4% | No |
Support to ST&T staff | 35 | 21 | 60.0% | No |
Qualified Healthcare Scientists | 6 | 3 | 50.0% | No |

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

**Multidisciplinary working**

Staff at different grades and skills worked well together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Outpatient teams worked together to plan and deliver care and treatment. Clinical staff we spoke with reported they had good working relationships with consultants. We were told if there were problems with consultants the nurse in charge of the department would step in to sort out any issues.

We saw both nurse-led and healthcare professional-led outpatient clinics across the outpatient areas. For example, physiologist-led continuous positive airway pressure (CPAP) clinics in the respiratory centre.

Specialist nurses worked across the outpatient areas. For example, in the cystic fibrosis department there was a specialist diabetic nurse who supported patients with their dietary needs.

During the inspection we observed good multidisciplinary working across many of the outpatient departments. For example, there was a multidisciplinary team in the neurology clinic who had gathered to see a patient with complex needs.

Some specialities had multidisciplinary (MDT) team meetings. For example, the cystic fibrosis department had a daily MDT meeting attended by consultants, nurses, psychologist, social workers, dietician, pharmacist and learning difficulties nurse for cystic fibrosis.

We saw oncology staff and Macmillan nurses worked together to provide continuity of care to patients.

The new manager in the patient service centre had initialised meetings with leading staff in the specialities to help better manage outpatient clinics, improve patient waiting times and reduce delays to follow ups. This was hoped to bring a more cohesive approach to the scheduling of outpatient appointments between the teams.

**Seven-day services**
Outpatient services were provided from 9am to 5pm Monday to Friday. Some specialties offered appointments with an earlier start and some clinics ran later in the evening but this was not standard practice across the outpatient departments.

Some specialties ran ad-hoc clinics on Saturdays to reduce waiting lists. The ophthalmology department had recently been running clinics on a Saturday to meet demand.

The chemotherapy department ran blood transfusion appointments on a Saturday but did not run chemotherapy appointments.

There was no formal plan for seven-day outpatient services. Out of hours and weekend clinics were organised on an ad hoc basis according to patient demand and consultant availability.

**Health Promotion**

**Staff were proactive in supporting people to live healthier lives.**

Doctors, nurses and health professionals promoted good health during consultations. Staff we spoke with told us that patients were made aware of health benefits from stopping smoking, reducing alcohol consumption and maintaining a healthy diet. One patient we spoke with told us that he had been informed of healthy living during their outpatient appointments.

We saw a range of health promoting leaflets and posters displayed in all but one of the outpatient departments we visited encouraging health promotion. This included leaflets on ‘time to quit smoking/ time to get moving/ take time out/call time on alcohol’ for patients with heart problems in the cardiovascular thoracic department and leaflets on respiratory conditions such as bronchiectasis, breathing pattern disorders, oxygen treatment in the respiratory department. In the chemotherapy department there was a poster board explaining about winter respiratory viruses including flu and how you could prevent catching them. The phlebotomy department was the only outpatient department we visited during the inspection that had no health promoting information for patients.

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

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.**

Clinical staff we spoke with had a good understanding of the consent procedure. They explained consent was gained verbally prior to procedures being performed and for more complex procedures a consent form would be necessary.

Staff and patients we spoke with told us consent was always obtained prior to treatment. We observed nurses, healthcare assistants and allied health professionals obtaining verbal consent throughout the outpatient departments. For example, when taking ECG measurements in the cardiovascular thoracic department, from patients in the chemotherapy unit prior to starting treatment and before taking blood samples in the phlebotomy department.
Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from September 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 89.8% of staff in the outpatient department compared to the trust target of 85.0%.

The breakdown by site was as follows:

- Southampton General Hospital: 87.7%
- Royal South Hants Hospital: 100.0%
- Princess Anne Hospital: 95.7%
- Lymington New Forest Hospital: 100.0%

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

Conversations with staff indicated they had a good understanding of their responsibilities towards the mental capacity (MCA) act and deprivation of liberty safeguards (DoLs). Staff in the ophthalmology department explained times when a patient might require a mental capacity assessment before attending clinics. Most staff we spoke with had not been involved in the process of DoLs. However, staff in the cystic fibrosis department could give us examples when they had to apply for a temporary DoLs.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff throughout outpatient services put patients at the centre of what they did. During the inspection we saw pleasant interactions between staff and patients. Staff spoke with patients and relatives in a kindly manner, using supportive language.

During the inspection we saw staff introduced themselves and took time to interact in a considerate manner. We were told by patients that no matter how busy the outpatient clinics and the demands on the staff, staff always tried to find the time to chat with them. We saw a staff member in the oncology department make time to catch up with one of the departments long-term patient in the waiting area even though they were busy.

Reception staff were attentive to the needs of patients and tried to maintained patient’s privacy and dignity. We observed receptionists speaking to patients in an attentive and polite manner in all outpatient areas we visited and we saw notices on the reception desk asking patients to respect others privacy whilst waiting to talk to the receptionist. We saw a receptionist in the cardiovascular thoracic/oncology department go out of their way to redirect a patient to the correct department when they had come to the wrong place for their appointment.

Staff understood the importance of chaperones. We saw posters in all outpatient departments we inspected offering chaperone services.
The privacy and dignity of patients could not always be protected due to constraints of the environment in the ophthalmology and cardiovascular thoracic departments. ECG assessments were carried out in a two-couch side room in the cardiovascular thoracic department. This room was used by mixed sexes, meaning different sexes could be next to each other whilst having their ECG assessment. However, the couches could be separated by a disposable curtain to help maintain the patient’s privacy and dignity. In the same unit patient’s heights, weights and blood pressure measurements were carried out in the corridor leading to the clinic rooms. We saw these measurements being taken during the inspection. No curtains or screens were used to separate off the area from other patients or staff. Therefore, we were not assured that patient’s privacy and dignity had been fully assessed or respected in these areas. In the ophthalmology department, vision tests were conducted in areas not concealed from the public view. During these examination other patients were observed waiting or walking through the area. This did not respect the patients’ privacy and dignity.

We saw many examples of compliments that outpatient departments had received from patients about the kindness and compassion displayed by staff. Cards and comments that staff had been given by patients and their relatives were displayed on notice boards throughout the outpatient departments.

We spoke to 22 patients and relatives across the Southampton General hospital and the Royal South Hants hospital during our inspection, many had used the service for a number of years. Patients and relatives were positive about their experiences of care. We heard that staff were kind and caring and that communication was clear, open and empathetic. Examples included;

- The staff are smiley, pleasant and explained the procedure
- Everyone is very caring
- The staff are happy and pleasant each visit
- The staff are excellent at taking blood, very pleasant and friendly
- The staff are friendly if a little busy due to lots of patients
- Staff very friendly and helpful

The trust gathered feedback through the NHS Friend and Family Test (FFT) survey. This is a tool that gives people that use the service the opportunity to highlight both good and poor patient experience. During our inspection we observed that FFT forms were available in the outpatient departments. Patients could either put completed forms in the box provided or complete the form online. Post inspection we requested FFT information from the outpatient departments.

**Friends and Family Test Results**

Below is the overview of FFT performance in the outpatient departments from January 2017 to December 2018.

<table>
<thead>
<tr>
<th></th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pos</td>
<td>Neg</td>
<td>Pos</td>
<td>Neg</td>
</tr>
<tr>
<td>Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>97%</td>
<td>1.3%</td>
<td>95.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Cardiovascular thorac</td>
<td>94.9%</td>
<td>2.5%</td>
<td>91%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>98.4%</td>
<td>1.6%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedic</td>
<td>97.5%</td>
<td>1.1%</td>
<td>99.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>100%</td>
<td>0%</td>
<td>96%</td>
<td>0%</td>
</tr>
</tbody>
</table>

FFT information for specialist medicine was further split up as can be seen below:
<table>
<thead>
<tr>
<th></th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pos</td>
<td>Neg</td>
<td>Pos</td>
<td>Neg</td>
</tr>
<tr>
<td>Cystic Fibrosis OPD</td>
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<tr>
<td>Dermatology Outpatients</td>
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<td>No data</td>
</tr>
<tr>
<td>Medicine D Floor</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Ophthalmology Outpatients</td>
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<td>0%</td>
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<td>No data</td>
</tr>
<tr>
<td>Optometry</td>
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<td>No data</td>
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<td>No data</td>
</tr>
<tr>
<td>Orthoptics</td>
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<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Pulmonary Function</td>
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<td>No data</td>
<td>No data</td>
<td>100%</td>
</tr>
<tr>
<td>Respiratory Centre</td>
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<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Victoria House</td>
<td>97%</td>
<td>1%</td>
<td>94%</td>
<td>3%</td>
</tr>
</tbody>
</table>

The trust overall had received over 95% recommend rate in the outpatient FFT. The trust did not supply us with the FFT response rate.

**Emotional support**

**Staff understood the need for emotional support.**

The hospital had a chaplaincy team who were on call 24 hours a day, seven days a week, who could provide listening and emotional support if requested by patients. The hospital also had a number of places around the trust set aside for the purposes of worship or quiet space.

Patients had access to the Macmillan information and support centre at the Southampton General hospital. The centre offered an information library, complementary therapies, counselling and benefit advice from trained staff and volunteers.

We were told by staff throughout the outpatient departments that a room would be made available if bad news had to be broken to patients. The neurology outpatient department had a safe room they could use for complex and vulnerable patients.

When talking to staff, it was clear how passionate they were about caring for their patients and how they put patients’ needs at the forefront of everything they did. Staff in the oncology department told us how, after the department had needed to close due to unforeseen circumstances during the day, the staff had stayed late so patients would still be seen on the day of their actual appointment. The staff told us they did not want their patients to suffer from the anxiety of waiting for a rearranged appointment at such an emotive time for them.

The cystic fibrosis team had received the trust’s team of the month in June 2018 in recognition of going above and beyond for one of their patients who had wanted to swim in the trust’s hydrotherapy pool. The team had worked together to make this possible for the patient and decorated the pool area with fairy lights to make the experience positive and extra special.

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

**Staff involved patients and those close to them in decisions about their care and**
treatment.

Patients told us they had received enough information before their appointment to prepare them for clinic. Although we were told by patients in the ophthalmology department that sometimes they would receive multiple letters with different dates and times for their appointment. This became confusing in knowing when their actual appointment was.

The majority of patients and relatives we spoke with across the outpatient departments said they felt actively involved in decisions about their loved one’s care and treatment. And were given time to ask questions. Examples included:

- I was involved in decisions
- The consultant explained things in ways I could understand
- I felt part of the decision
- All my questions were answered

We observed in the cardiovascular department nurses and healthcare assistants explaining to patients what was going to happen during their clinic appointment. They made sure patients understood and used language appropriate to the patient.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and was working towards providing services that met the needs of local people.

Outpatient services and clinics were provided from different locations in the local area, Southampton General hospital (SGH), Royal South Hants hospital (RSH), Lymington New Forest hospital, Princess Anne hospital and Countess Mountbatten House. However, the majority of clinics were located at the Southampton General hospital.

The patient service centre was responsible for booking all new outpatient appointments and most follow up appointments. The centre was open Monday to Friday 8am - 8pm and Saturday mornings 8.30am – 12.30pm. The extended opening hours were to ensure that patients who did not have access to phones during the day had the ability to book appointments. The trust was now using the national e-referral service across all its outpatient services. This meant that patients and GPs could directly book services using the electronic choose and book system.

To help reduce patients not attending their clinic appointments patients received a telephone reminder seven days prior to their appointments and were asked to confirm they would be attending. This call was automated. Two days prior to the appointment patients would receive a text reminder. Patients had the opportunity to opt out of this service if they so wished by contacting the patient service centre.

Information supplied by the trust post inspection showed they was an 7.7% DNA rate across all outpatient services for the previous year.

**Did not attend rate**
From July 2017 to June 2018,

- the ‘did not attend’ rate for Lymington Hospital (Peripheral Clinic) was lower than the England average except for in August 2017 when the ‘did not attend’ rate was higher than the England average.
- the ‘did not attend’ rate for Princess Anne Hospital was lower than the England average.
- the ‘did not attend’ rate for Queen Alexandra Hospital Peripheral Clinic was higher than the England average during July, August, September 2017, December and February 2018. Queen Alexandra Hospital Peripheral Clinic ‘did not attend’ rate was lower than the England average in October 2017 and May 2018. Queen Alexandra Hospital Peripheral Clinic was similar to the England average for the remaining five months.
- the ‘did not attend’ rate for Royal South Hants Hospital was lower than the England average.
- the ‘did not attend’ rate for Southampton General Hospital was lower than the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, University Hospital Southampton NHS Foundation Trust.

(Source: Hospital Episode Statistics)

Southampton General hospital had two car parks, the main car park and an overspill carpark with extra spaces. This car park was closer to the neurological and oncology centres and the eye unit. The trust website provided clear information for patients travelling to the hospital by both car or public transport. The patients we spoke to during the inspection gave us mixed reviews about getting to the hospital, with some saying it was hard to park and they were resentful having to pay car parking charges when their appointments overran, to others saying they had no problems getting to the hospital. Patients in the ophthalmology department did comment that they would rather come to the Southampton General Hospital than the Lymington New Forest hospital due to difficult transport links to get to Lymington.

Southampton General Hospital was a large hospital with an east wing, centre block and west
wing. Signposting to the outpatient departments was in general good and patients told us it was relatively easy to find the department they wanted. Signposts to the eye department were yellow which made it easier to find the department. However, senior staff in the eye department told us they hoped one day to change the signs to black text on a yellow background as this was considered the best colour combination for visually impaired people. Volunteers could be found at the main reception desk at the entrance to the hospital and we observed them advising patients how to get to the right clinical areas. We also observed staff asking patients/visitors if they needed help if they were looking lost in the hospital corridors.

In some departments the environment did not meet the needs of the volume of patients seen. The eye unit at the SGH was too small to meet the needs of the number of patients and clinics running. We saw areas were cramped. The chemotherapy unit was a 10 chair unit but capability was increasing and the area was too small to increase the number of patients seen at one time.

We were told by senior staff working in the eye department to help increase capability, clinics were now being offered at Lymington New Forest hospital. However, they realised a longer-term solution needed to be found, which could include; virtual clinics, looking at the current environment to increase flow, an increased use of Lymington New Forest hospital and looking at hub and spoke models. Which meant having multiple practicing sites where the ‘hub’ was the anchor site of the speciality and the ‘spokes’ were connecting secondary sites serving that speciality. We asked if there was a strategy with action plans for the work needed in the eye department to increase capability and were told that discussions were in their infancy and as yet no strategy had been formally completed.

The chemotherapy team told us they offered an outreach service at the Countess Mountbatten House and in Lymington but nurses had to travel to these sites by taxi. However, they had recently been provided with a car by a local charity which meant it was easier to travel to outreach centres. This meant they could continue offering treatment closer to patients’ homes. Nurses we spoke with told us how valuable this service was but also commented it meant two nurses had to be allocated to this service which could leave them short of nurses in the chemotherapy suite at the SGH.

The outpatient service ran rapid access clinics. There were rapid access clinics that supported patients receiving care in a timely manner without being admitted to the emergency department such as ophthalmology services in the eye casualty unit and the head and neck hot clinic which offered assessments and minor procedures for urgent patients. Other rapid access clinics ran daily Monday to Friday such as the nurse-led rapid access chest pain clinic and the rapid access vascular clinic.

In the ophthalmology department there was a dispensing service for glasses. Patients would either present with their prescription or consultants would talk directly to the dispenser if it was a complex case.

**Meeting people’s individual needs**

The service took account of patient’s individual needs, they tried to plan and provide services in a way that met the needs of the people.
Most patients we spoke with were happy with the appointment letter they had been sent before attending the hospital. However, some patients in the ophthalmology department told us they either didn’t receive a letter or had received multiple letters with different appointment times and dates on them. This could make it confusing knowing which was their actual appointment.

The trust had good plans in place to contact and look after patients with no fixed abode who needed to attend outpatient clinics.

Patient transport services were available to those patients that met the eligibility criteria based on the department of health guidance. We saw notices throughout the outpatient departments reminding patients to inform staff if they were using patient transport services so staff could contact the transport services to get their returned transported booked and on the system. In the orthopaedic department patients arriving by transport were flagged and they were moved higher on the clinic list to make sure they did not require transport to take them home during rush hour, which let to patient transport delays. Staff in most outpatient departments reported problems with the transport service, for example we were told they would be kept waiting after the department had closed with patients waiting for transport to take them home as transport was often delayed.

Not all clinics had easy access or enough space to fit wheelchairs in. High-back chairs with arms to accommodate older patients or those with mobility issues were not available in most outpatient waiting areas. Bariatric chairs were seen in the majority of waiting areas.

The majority of outpatient clinics had a receptionist where patients could book in when they arrived. Some clinics, for example in the neurology outpatient department, had a self-check in screen. We were told by staff working in the department that patients did not like using the screen with comments being they did not want to touch the screen due to the possible infection risks.

In many of the outpatient departments we saw signs telling hearing impaired patients there was a hearing loop. This is a special type of sound system for use by people with hearing aids. The hearing loop provides a magnetic, wireless signal that can be picked up by the patient’s hearing aid when it is set to a certain setting. This can help reduced background noise and competing sounds that lessen clarity of sound in a public area.

There was a mixture of information presented to patients when entering the different outpatient departments, some clinics had photo boards of key members of staff, some had a list of which consultants were running clinics that day, some had information on clinical staff’s uniforms. However, there was no standardisation across all outpatient departments on what information should be on display to the patients.

Although translation services were accessible across the outpatient services there was no information displayed to let patients know this. However, information on the trust webpage did advertise that a translation service was available at the trust in English and five other languages. We were told by staff working in the outpatient departments that if an interpreter or sign language was needed by a patient in clinic, the patient services centre (PSC) could book an interpreter prior to the appointment. Although staff said they mainly used friends and family of patients to help translate if needed. This is not best practice as interpretation undertaken by people involved with the patient may be distorted (due to over protectiveness, bias, conflicting interests or lack of understanding of clinical terminology) and may not be an appropriate way of communicating confidential information. The trust ran a course for staff with an existing foreign language skill to become a trust-wide translator. Staff in the ophthalmology department were keen to undertake this course as they thought it would help them interact with their patients better.
We observed a range of relevant patient information leaflets were available in the outpatient departments. Patients could access leaflets in large print, braille or on audiotape if needed. Leaflets were in English however we saw signs, in English, telling patients leaflets could be downloaded via organisational websites in another language if needed.

Patients with additional needs or requirements were flagged on the appointment system, meaning that staff could plan for their visit in clinic appropriately. Staff in the ophthalmology department gave out different coloured cards to the more vulnerable patients, green if they had less complex needs for example, they needed help with their mobility and orange cards to patients needing more support, for example, dementia. This ensured that in a busy clinic staff could pay particular attention to them and make sure their individual needs were met. During our inspection we observed a patient with complex needs attending an appointment in the neurology department with their carers. The patient was known to the team and the scheduled meeting needed a multidisciplinary (MDT) team. The patient arrived in a distressed state. The MDT team was not gathered at the allocated appointment time and the patient was made to wait in the noisy crowded waiting room rather than the empty safe room. A safe room is a quiet room away from noise, other patients and environment risks. This led to the patient becoming more distressed and upsetting the other patients in the waiting area. We were not assured that the neurology department had a good understanding of the needs or addressed the needs of the patient, used the facilities in the department appropriately or had put plans in place to accommodate the patient.

Staff we spoke with, understood the importance of chaperones and they explained they provided them on request or would offer their services. We saw posters in outpatient areas offering chaperone services. We were told by patients we spoke with that a chaperone had been offered to them.

In the cystic fibrosis department which did not run every day, administration staff had been taught to triage patient calls. This meant patients could call in Monday to Friday if they needed support. Out of hours patients could call the cystic fibrosis inpatient ward.

### Access and flow

**Most people could access the service when they needed it. Waiting times from referral to treatment were not in line with good practice for all of the outpatient specialities.**

The NHS constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All NHS acute hospitals are required to submit performance data to NHS England, who then publish a report on how hospitals perform against this standard. The maximum waiting time for non-emergency consultant-led treatments is 18 weeks from the day a patient’s appointment is booked through the NHS e-referral service or when the hospital or service receives the referral letter.

### Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From September 2017 to August 2018 the trust’s referral to treatment time (RTT) for non-
admitted pathways has been worse the England overall performance. The latest figures for August 2018, showed 86.1% of this group of patients were treated within 18 weeks versus the England average of 88.4%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, University Hospital Southampton NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Seven 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>General medicine</td>
<td>98.7%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.6%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>96.1%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>95.9%</td>
<td>89.1%</td>
</tr>
<tr>
<td>General surgery</td>
<td>94.9%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>87.1%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>85.2%</td>
<td>83.5%</td>
</tr>
</tbody>
</table>

Eleven 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>Gynaecology</td>
<td>88.2%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Urology</td>
<td>86.8%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>86.5%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Other</td>
<td>86.5%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>85.8%</td>
<td>87.0%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>84.2%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>80.5%</td>
<td>88.3%</td>
</tr>
</tbody>
</table>
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From September 2017 to August 2018 the trust’s referral to treatment time (RTT) for incomplete pathways has been similar to the England overall performance. The latest figures for August 2018, showed 86.9% of this group of patients were treated within 18 weeks versus the England average of 86.8%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, University Hospital Southampton NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Eight 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>Dermatology</td>
<td>96.4%</td>
<td>90.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>96.4%</td>
<td>89.7%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>93.9%</td>
<td>88.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>91.1%</td>
<td>84.3%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>90.3%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>90.0%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>86.7%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>86.2%</td>
<td>84.5%</td>
</tr>
</tbody>
</table>
Ten 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>General medicine</td>
<td>92.2%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>90.2%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Other</td>
<td>89.3%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>86.5%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>85.6%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>85.6%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>82.6%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>81.4%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>80.3%</td>
<td>85.7%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>75.8%</td>
<td>82.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

There are different targets for patients with symptoms that could be due to cancer. In England, patients should wait no longer than two weeks from an urgent GP referral to seeing a specialist. In addition, there should be no more than 62 days waiting time from the date the hospital receives the urgent referral and the start of treatment and no more than 31 days waiting time from the meeting at which the patient and the doctor agree a treatment plan and the start of treatment.

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust performance has declined in the latest quarter below the standard and England average. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), University Hospital Southampton NHS Foundation 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)

The trust is performing worse than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). Performance has dropped below the national standard and England average in the latest three quarters. The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), University Hospital Southampton NHS Foundation Trust

![Graph showing percentage of people waiting less than 31 days from diagnosis to first definitive treatment](source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. Performance has dropped below the national standard and England average in the latest two quarters. 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, University Hospital Southampton NHS Foundation Trust

![Graph showing percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment](source: NHS England – Cancer Waits)

During the inspection we discussed cancer waiting times with senior members of the cancer care group as targets have been seen to be falling. We were told there were many reasons why this was happening, increasing patient numbers and lack of capacity in clinics; lack of staffing in the speciality; patients being referred from other hospitals late in their pathways and the capacity of supporting service, for example getting tests results back in a timely way. We were told there was a weekly performance meeting to discuss cancer waiting times and there was a dedicated group in the patient service centre that looked after the booking of the initial appointment to make
sure they were within the two-week window from the referral. We were told the service was continuously looking at ways to reduce waiting times but it was a constant challenge.

Referral to treatment times (RTT) were usually monitored by the operational manager in the speciality care group rather than within the patient service centre. The newly appointed manager of the patient service centre (PSC) was beginning to work closer with the care groups to have a joined-up approach to maintain or reduce RTT times in outpatients.

Most patients we spoke with told us availability of appointments was good.

The patient service centre had its own monthly targets to answer patient calls in 45 seconds. The month prior to the inspection the centre answered 90% of its calls within this time frame. However, the average waiting time overall was 59 seconds.

Information provided by the trust post inspection showed that in 2018 that 8.7% of outpatient clinics had been cancelled. 5.1% were cancelled six weeks or more prior to the appointment date and 3.6% were cancelled less than six weeks prior to the appointment date. Ophthalmology and trauma & orthopaedics were the outpatient departments with the highest cancellation rate of 13% and 10% respectively. The main reason for appointment cancellations were due to rescheduling of the patient (3%) or staff absent (5%).

Cancellations were monitored by the medical specialities in the care groups. The patient service centre had piloted a scheme where if they were informed of any cancellation in clinic they there could offer a short notice appointment. This meant a text message would be sent to patients who had indicated that they would be available for clinics at short notice. Patients who responded first would be allocated the cancelled appointment slot. This was a responsive way to make sure clinics ran full.

We were told by staff in the ophthalmology department that patients whom clinical staff were not expecting would turn up for appointments. Clinical staff across the outpatient departments told us they would try very hard not to turn patients away and would fit them into clinic. This was responsive but could lead to delays for other patients waiting in the clinic.

We were told by staff that delays in appointment times would be announced to patients in waiting areas, either verbally or on electronic screens / whiteboards. Although we saw space for staff to show waiting times in the outpatient clinics we visited, most clinics we visited did not display waiting times or delays in waiting times. Many of the patients we spoke with during the inspection had been waiting over 30 minutes for their appointments.

The service did not routinely measure the number of patients who were not seen within 30 minutes of their appointment time. This meant the service was not collecting evidence-based information to know how many appointments ran late, to understand why appointments were running late and ultimately help improve the quality of outpatient services.

We were told by staff working in the ophthalmology department that patients currently waited approximately 45 minutes for a visual acuity test. Most patients in the eye department started their appointment with this test before continuing on to seeing the consultant. Currently the unit had four lanes to test patient’s vision. The team had carried out a pilot scheme to see if increasing the vision lanes to six would reduce waiting times and improve patient flow through the
department. On testing it was found that increasing the lanes to six reduced the patient waiting
time to 17 minutes and did improve flow. However, more environmental space and more staff
were needed to regularly run six vision lanes. Currently this was one of the ideas being discussed
by the board to help improve the service offered in the ophthalmology department.

Patients in the phlebotomy clinics took a ticket and waited for their number to be called. Staff told
us waiting times in the phlebotomy clinic varied between 10 – 40 minutes depending on how busy
the clinic was and how many phlebotomists were on shift.

In the ophthalmology waiting area there was colour-coded seating. Each colour represented an
element of the patient’s pathway. The red, amber and green seating enabled clinical staff to
assess how many patients were waiting for a particular treatment or clinician within their large,
busy department. We were told by staff it helped as they could identify more quickly how many
patients were waiting. However, as the department was so busy and seating limited often
patients would be sitting on the wrong coloured chair as that was the only available seating.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned
lessons from the results, which was shared with staff. However, the trust did not always
respond to complaints in a timely manner.

Summary of complaints

From September 2017 to August 2018 there were 87 complaints about outpatient services. The
trust took an average of 55.0 days to investigate and close complaints, this is not in line with their
complaints policy, which states complaints should be closed within 35 working days.

- Southampton General Hospital: There were 74 complaints. The following subjects had three or
more complaints:
  - Communication with patient; nine complaints
  - Appointment delay (including length of wait); eight complaints
  - Appointment - failure to provide follow up; five complaints
  - Attitude of medical staff; four complaints
  - Post-treatment complications; three complaints
  - Failure to act in a professional manner; three complaints
  - Delay in treatment; three complaints
  - Delay/ failure in treatment/ procedure; three complaints
- Lymington Hospital; one complaint due to delayed appointment.
- Princess Anne Hospital: five complaints:
  - Communication with patient; three complaints
  - Inappropriate treatment; one complaint
  - Breakdown in communications; one complaint
- Royal South Hants Hospital: seven complaints:
  - Post-treatment complications; two complaints
  - Delay/ failure to diagnose (including missed fracture); two complaints
  - Attitude of medical staff; one complaint
• Delay/ failure in treatment/ procedure; one complaint
• Inappropriate treatment; one complaint

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

Number of compliments made to the trust

From September 2017 to August 2018, there were no compliments within outpatients.

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

Staff in the outpatient departments told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. If the problem could not be resolved by the team, staff told us patients would be given contact details of the patient support service.

Information regarding the services the patient support service offered, including how to make a formal complaint and how to contact them, was displayed in prominent areas in the outpatient departments, in the form of posters and a ‘have you say’ leaflet. Information could also be found on the trust website, including a ‘have your say’ leaflet you could download. The service had a visible presence within the main entrance of the hospital with their offices open Monday to Friday 9am to 4pm.

Outpatient staff told us that feedback from complaints and concerns were discussed at the team meetings, during daily face to face catch ups and in handover sessions. Staff we spoke with could give us good examples of learning from complaints and concerns and genuinely viewed these as an opportunity for improvement. Staff in the phlebotomy department told us patients had complained about long waits at the Lymington hospital. The team responded to the complaint by opening an additional chair, which had reduced waiting times and the complaints made. The staff in the rheumatology and managed care department escalated complaints about parking and this had let to disabled parking spaces outside the department.

There seemed to be no universal approach on how to display and feedback learning from patient complaints in the outpatient departments.

The specialist medicine matrons ran a specialist medicine matron’s helpline. The service had been set up in July 2018 in response to complaints being centred around communication issues. The helpline was open to staff, patients and their families to call and made the matrons more accessible to all with the hope that issues could be de-escalated before they became complaints. The service was advertised in all the specialist medicines areas in the hospital. During the inspection we saw posters in the specialist medicine outpatient departments. Although there had been no formal evaluation of the service we were told the initial observations showed, no patients or families had rung the helpline, although staff had rung to get the matrons to speak to patients and families. There had been a reduction in the number of formal patient complaints, more empathise on shared learning amongst the matrons and better communications through the specialist medicine team.

We reviewed minutes from monthly care group governance meetings and saw that complaints were discussed.
Is the service well-led?

Leadership

Managers in the trust had the right skills and abilities to run a service providing high-quality sustainable care. However, it was unsure if senior staff had full oversight of the outpatient departments.

The trust was split into four divisions: division A, division B, division C and division D. Each division had a management structure in place and clear lines of responsibility and accountability. The divisions were further split up into medical speciality care groups, with each care group having a care group clinical lead, care group manager and one or more matrons.

Outpatient departments were managed in the care group to which the medical speciality belonged and management was the same for all trust locations. The patient service centre sat in division C under the support services care group.

The majority of outpatient departments were managed on a day to day basis by a band 7 nurse with a team made up of band 2 to band 6 clinical and non-clinical staff. The band 7 nurse reported to the matron of the care group in which the outpatient department belonged to. The majority of matrons and care group managers where responsible for both the inpatient and outpatient areas in their speciality.

During the inspection we met and spoke with the band 7 leads in the outpatient departments. We found them to be enthusiastic, keen to improve their departments and supportive of their teams. In some of the teams, for example the ophthalmology department and the cardiovascular/oncology department, there had been recent changes in the band 7 role. The majority of staff we spoke with spoke highly of their band 7’s and this was especially true in the teams where the new band 7’s had been employed.

At clinic level throughout the outpatient departments we did not see matrons present. However, senior nursing staff told us they could contact their matrons when necessary and they found them to be supportive and approachable. However, we were unsure of the oversight matrons had for their outpatient departments. For example, when speaking to some matrons they could tell us in great detail about their responsibilities and how the inpatient services run but this was not the case when questioned about their outpatient departments.

There had been some new appointments in prominent positions in the outpatient departments and the patient service centre. It was too early days to see the impact these staff were having on the services. However, staff working in the departments were already impressed with changes and the decisions being made.

We were told by staff working in some of the outpatient departments we inspected that outpatient departments had been side-lined in the past. However, staff could see changes beginning to happen with outpatients having more of a profile in the trust.

Outpatient staff at all levels spoke positively about the trust leadership team. We were told the chief executive and board members did walk rounds of departments.
Vision and strategy

The trust had a vision for what it wanted to achieve and were working on plans to turn it into action.

The trust had a vision as summarised in their Forward document to ‘work with their partners at the edge of healthcare for the benefits of their patients’. How they planned to achieve this was detailed in their Operational plan 2017-19 which included the trust’s approach to quality, activity, workforce and finance planning for the next two years. In addition, the trust had a patient safety strategy (2015 - 2018), a patient experience strategy (December 2012 – December 2016) and a quality governance strategy (2014 - 2017). All three strategies were needing review.

At an outpatient services level the operational plan included needing to reduce face to face outpatient follow-up appointments by 2020/21, reduce the DNA rate, to introduce new models of care outside of the hospital and to introduce a digital platform for patient booking and clinic management. The trust had a dedicated outpatient transformation steering group to develop a programme to reach these targets without compromising patient care and safety. Some progress had been made in the new to follow-up ratio, non-face to face appointments with patients being able to access their test results, upload clinical data and communicate securely with their clinical team through a digital platform. We were told by the trust a business case for accelerating the outpatient transformation programme was presented to the transformation board in November 2018 and the steering group were waiting to find out the outcome from this meeting.

We saw evidence of local adaptation of the outpatient transformation strategy whilst visiting the outpatient departments. For example, in the trauma and orthopaedics services the introduction of a virtual fracture clinic and virtual hip/knee clinic had seen a reduction in the patient wait time and DNA rates and in the rheumatology department had seen a reduction in follow up appointments by introducing a smartphone application that could manage early onset arthritis.

Although we were told about many of the new ways of working in the outpatient departments we inspected, staff did not tell us they were part of the outpatient transformation programme. Therefore, we were unclear how well the vision for outpatient services was being communicated down to staff working in the clinical areas.

Staff we spoke with were aware of the trust’s values of ‘putting patients first’, ‘working together’ and ‘always improving’. Staff told us these were the values they worked by each day.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The majority of staff we spoke with felt supported, respected and valued in their working environments and we could see this in practice when we inspected the outpatient departments. Staff described good teamwork amongst their colleagues and how they often felt their teams were like family.
Staff confirmed that they felt able to be open and transparent, reporting adverse events and incidents in a way which helped improve things within the service.

Across the outpatient departments staff told us they were proud of the service they provided to patients.

We were told by staff working in the outpatient departments that the culture had changed for the better. For example, consultant behaviour did not go unchallenged where it would have done in the past and bad behaviour was no longer tolerated.

We were told by staff working in the ophthalmology department since the change of key personnel department had improved and they were included more in decision making and communication was better.

As per NHS guidelines the trust had appointed a Freedom to Speak Up Guardian whom staff could talk to in confidence if they had concerns. Staff in the outpatient departments we spoke with were aware of the freedom to speak up guardian but had no experience of using the service.

**Governance**

**There was no overarching governance structure for outpatient services. Outpatient services were managed under care groups specific to the clinical service.**

Outpatient services were discussed at the monthly care group governance meeting for their medical speciality. For example, the chemotherapy department was discussed at the cancer care group governance meeting and the respiratory centre was discussed at the specialist medicine care group governance meeting.

Information from the care group governance meetings would feed up to the division governance groups. They in turn would feed up to the trust quality governance steering group (QGSG) which reported to the trust executive committee and ultimately the trust board. This showed a ward to board governance process.

We reviewed three months of minutes from the care group governance meetings and found that key quality issues of safety, risk, clinical effectiveness and patient experience was discussed. However, not all care groups had the outpatient department as a standard item on the agenda.

Meetings were consistent in their agendas in their divisions. For example, the ophthalmology care group used the same agenda as the specialist medicine care group, who were both in division B and the cardiovascular and thoracic care group used the same agenda as neurosciences care group who were both in division D. However, there was no standardisation between the divisions, division B and division D used different meeting agendas. This meant the trust could not be assured that divisions were covering the same topics in their governance meetings.

For some outpatient departments the matrons would prepare an exception report to take to the care group governance meeting. This included information on identified risks, non-compliance of performance against targets, complaints and action plan updates. We saw examples of exception reports from the ENT and surgical outpatient departments but staff were unsure if this report was used across all care groups in preparation for governance meetings.
We were told by staff in the outpatient departments that local staff meetings were held between the matron and the band 7 responsible for the day to day running departments and meetings outpatient team meetings. In these meetings information would be exchanged and concerns highlighted. Post inspection we requested minutes from these meetings but it seemed these meetings were more informal and were not minuted. Therefore, it was unclear how often these meetings took place and what information was shared within the team.

Some outpatient departments had introduced a morning huddle to update staff on the work plan for the day and any clinical or non-clinical issues. Staff told us they found these meetings useful and helped them keep up to date and plan for the day.

Senior staff in the outpatient departments told us they used different methods to disseminate information to their staff, with the use of emails, newsletters, lunchtime meetings and information displayed in staff rooms. During out inspection we saw this in practice.

**Management of risk, issues and performance**

The trust had systems for identifying risks, issues and performance and could cope with both the expected and unexpected.

The trust documented risk on different risk registers depending on the type of risk they were capturing. The trust’s corporate risk register captured overarching trust risks that would impact on the trust’s ability to deliver services. Outpatient services had one risk on the corporate risk register, the insufficient clinical and environmental capacity to meet rising demand for outpatients. Other risks relating to medical services were captured on the division’s risk registers. The four divisions had their own risk registers.

Individual outpatient departments did not hold local risk registers as risks requiring oversight were added to the division risk registers. Although risks were added to the division’s risk register we were told by the trust that risks were managed at the care group level.

Risk that reached a certain criteria or was thought to be of high enough risk would be placed on the corporate risk register.

It was unclear how outpatient services identified risk, although we were told post inspection that staff in the outpatient departments would fill out risk assessment forms if they suspected there was a risk in their local area of magnitude with help from senior staff. This would then be discussed at the care group governance meetings where it would be decided if it was a high enough risk to be added to the care group’s risk register.

When we reviewed minutes from the care group governance meetings we saw risks were discussed. Post inspection we requested the risk registers for the four divisions. From the information we received we could see that risks were documented with information on when the risk was created, risk description, consequence description, current controls and any gaps in control. Risks were rated and actions agreed on how to migrate the risk and who had ownership of the risk. However, there was nowhere to record progress or date of last review of risk. It was unclear if we had been sent the whole risk registers or just examples of risks from the divisions.
Therefore, it was difficult to know if all the risks we had been told about in the outpatient departments during the inspection were captured on the risk registers.

The care group managers were responsible for the collection and monitoring of performance indicators, such as referral to treatment time and cancer wait times, and would use this information to improve the quality of the service. We saw evidence from the minutes of the relevant governance and operational care group meetings that this data was discussed and used to improve outpatient services.

The patient service centre had started to implement meetings with each of the care group managers to discuss outpatient patient outcomes with the hope of working together to improve outcomes. It was too early to see if this combined approach was having an impact.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust used computer toolkits and dashboards to collect and monitor the outpatient services operational performance in national, commissioning and internal targets. Data on staffing, quality and safety was collected and reviewed.

The trust had started to implement an electronic document management system. This meant that patients records were available electronically and patient information could be captured electronically at the point of patient care. Most outpatient departments we inspected were paper light and moving towards electronic data capture. This meant all patient information was in the same place and easily accessible to staff, which improved patient safety and the patient experience.

The trust had a webpage where the public could access much information about the hospital, including information about the trust, patient services, patient and visitor’s information, how to make complaints and compliments and the latest hospital news.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The trust encouraged public engagement. They offered the friends and family test for the public to feed back their comments and help improve the outpatient services. They could do this on a paper form found in the outpatient departments or via the ‘patient and satisfaction’ tab on the trust’s website where patients could leave electronic feedback about their hospital experiences.

The trust had a website where the public could access much information about the trust and its hospitals including information about the outpatient clinics and services. There was information on the latest hospital news, charity news and when the trust had been in the media. The public could
also find on the website details about how to get involved with clinical research, find details on support groups and the chief executive’s blog.

However, not all the information was kept up to date, for example the last chief executive’s blog was June 2018 and since then a new chief executive has come into post.

The trust also kept the public updated on twitter, Facebook and Instagram. Information on trust news, events and media stories were shared here.

The trust took part in the NHS staff survey and used the results to tackle and measure issues or themes raised by the staff. In the 2017 survey, the response rate of staff completing the survey was 45%. When benchmarked against other NHS trusts, the University hospital of Southampton was ranked as the best in the south for recommendation of a place to work and be treated. Areas of concern were issues with equality and diversity and violence and aggression. Whilst inspecting in the outpatient departments these were not issues raised by the staff we spoke with. We saw that the staff survey results were discussed at the care group meetings.

The trust provided information on their intranet pages and produced a newsletter and sent emails to keep staff updated on current and future plans and trust information. It was the individual’s responsibility to read the information supplied. Outpatient staff we spoke with didn’t always have access to computers to read emails regularly and said it was easy to miss newsletters but they did their best to keep up to date with trust news. They told us senior staff gave them information they needed to know to carry out their roles.

The trust ran the hospital heroes annual awards scheme to give recognition to staff and volunteers who had given exemplary service. These awards acknowledged individuals and teams who had made a significant contribution to the patient experience whether working directly with patients or behind the scenes supporting those delivering front line services.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Many staff we spoke with from the outpatient departments had ideas of how they could improve the area they worked in. For example, the oral and maxillofacial department had made plans for a new footprint for the department that would use the space better and help increase capability and efficiency which they hoped they could take forward. The senior nurse of the department had been nominated for a ‘healthy ideas award’ from the trust for suggesting that sterile pharmaceutical items that were soon to expire be reallocated to a different department that had high usage of the item to avoid wastage.

The trust was a major centre for teaching and research in association with the University of Southampton and other partners. Research studies and clinical trials are how we understand health better and develop new ways of treating or managing conditions. Whilst inspecting we saw many posters in the outpatient departments advertising for volunteers to take part in medical research programmes.