

University Hospital Southampton NHS Foundation  
Trust

# Southampton General Hospital

## Quality Report

Southampton General Hospital  
Tremona Road  
Southampton  
Hampshire  
SO16 6YD  
Tel: 02380777222  
Website: [www.uhs.nhs.uk](http://www.uhs.nhs.uk)

Date of inspection visit: 27-29 January 2017 and 7  
February 2017 unannounced  
Date of publication: 13/06/2017

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

### Ratings

|                                    |             |   |
|------------------------------------|-------------|---|
| Overall rating for this hospital   | Good        |  |
| Surgery                            | Good        |  |
| Critical care                      | Outstanding |  |
| End of life care                   | Good        |  |
| Outpatients and diagnostic imaging | Good        |  |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We carried out a focused inspection at Southampton General Hospital between 25 and 27 January 2017, and the unannounced inspection took place on 7 February 2017. This inspection was to follow up our comprehensive inspection in 2015 where some services had required improvement.

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. The trust includes Southampton General Hospital, the Princess Anne Hospital and Countess Mountbatten House, and also runs outpatient services from the Royal South Hants Hospital.

During this inspection we inspected Southampton General Hospital only.

During this inspection, we found that there had been an improvement in the quality of services provided since our previous inspection in 2015.

Patients were at the heart of all major trust decisions, and this was clearly evidenced by the executive team and board's adherence to the trust values, a pro-active research and learning culture, and consistent support of staff to deliver "ever-better" care. The trust was managing the pressure on beds and capacity to the best of its ability, given the wider health economy pressures locally and regionally.

We have rated the individual services of Surgery, Critical Care, End of Life Care, and Outpatient and Diagnostic Imaging services. These services were selected because they were rated as 'requires improvement' at our inspection 2015: however with improvements, these services have now been rated as either 'good' or "outstanding".

We also inspected the 'well led' domain which examines the governance and leadership of the overall trust by the senior, executive and non-executive leadership and management. This part of the process was a short-notice inspection, and the inspection rating and outcome for 'well-led' can be found on the separate provider report.

During this inspection, with the Trust's prior agreement, we asked some pilot questions about the application of mental health service frameworks within these acute core services.

### **Our key findings were as follows:**

- Staff treated people with kindness, compassion, respect and dignity. The feedback from patients, their relatives and carers was highly positive, and many people contacted us before, during and after the inspection to tell us this.
- Staff at all levels told us of the inspirational and facilitative leadership of the Chief Executive Officer. The Chief Operating Officer, Medical Director and Director of Nursing were also widely acknowledged as providing a high level of support, knowledge and participative leadership to the staff they led.
- The governance structures provided an effective, efficient and easily accessed system for staff to escalate areas of concern, and this drove continuous improvement to performance, quality, and service outcomes.
- The trust had an effective system for reporting and recording incidents. Risks were known and mitigated, and staff confirmed learning and feedback took place. This was often, although not always, cascaded to other areas for maximum benefit.
- The duty of candour was monitored through the online incident recording system, and supported by the trust's 'Being Open' policy.
- The hospital areas inspected were visibly clean. Cleaning schedules were used, were mainly up to date and completed. Cleaning audits for 2016 consistently met the target of 98% compliance by internal staff and by contractors.

# Summary of findings

- Staff were observed to comply with infection prevention and control practices, were below the elbow and used hand wash facilities where required.
- Medicines were stored safely, securely and mainly appropriately. However, within the critical care environments, high fridge temperatures had been noted on a few occasions, with no assurance that action had been taken to remove the medications within.
- Records were a mixture of electronic and paper formats. Records review showed that in the majority written records were complete, legible, dated and signed. However, in surgery we found concerns with the completeness of records and illegible signatures.
- ‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) records were completed well for the majority of patients whose records we reviewed. However, the care interventions in the end of life care records were inconsistently completed for some patients.
- Safeguarding policies and procedures were in place for adults and children, and training was mandatory for all staff with the level of training undertaken appropriate to the individual’s role. Most staff demonstrated a clear understanding of how to identify report and protect patients from potential harm or abuse, in line with their trust policies. However, some staff in the outpatient departments were only able to demonstrate a basic understanding of safeguarding issues.
- The trust had made significant progress with nurse recruitment since our previous inspection in 2014. Whilst some areas, such as surgery, still had high vacancy rates, overall the trust vacancy rate was reducing.
- Medical staffing levels were sufficient in surgery, critical care and outpatients and diagnostic imaging. In end of life care, the palliative care consultant cover had increased from the last inspection but was still below the national recommendation. However, a business case had been written to address this and recruitment was underway.
- The trust had a clinical effectiveness and outcomes steering group which monitored the compliance of National Institute for health and Clinical Excellence guidance, and quality standards.
- There was effective multi-disciplinary working within teams in all the cores services we inspected, and with external healthcare partners.
- Consent was sought and documented before care or treatment was given. There was evidence that capacity assessments and best interests decisions took place.
- Relatives and carers were supported by a “Carer’s Café” held every week to provide advice and support.
- The trust had detailed processes and staff in place to support patients with complex needs including learning disabilities and dementia.
- Patients could access a range of nurse specialists for their conditions including diabetes, oncology, respiratory and urology.
- The trusts performance in referral to treatment times was better than the England average, and outpatient departments consistently achieved the two week wait for urgent cancer referrals.
- The trust had an effective system to handle, monitor and subsequently learn from complaints.
- The four core services had effective local leadership, with visible and mainly approachable senior leads. Staff felt supported and valued, and were enabled to “lead upwards”.

## **We saw several areas of outstanding practice including:**

- The hospital has a large volunteer body of over 1000 people. Some of the volunteers work as mealtime assistants to support those who need extra help or time to eat.
- There were outstanding examples of multidisciplinary team working and communication with safe patient care at the forefront of handovers.
- The trust had a new ‘talent management’ project and ten staff had been recently accepted.
- The neurological intensive care unit had developed sophisticated strategies to ensure the continued wellbeing of their patients who presented with challenging behaviour when cared for within an acute clinical environment. This benefitted not just patients, but also protected relatives and staff from the possibility of unintentional violence.

# Summary of findings

- All the critical care nurses had completed specific training to give them extended scopes of practice. This included interpreting chest X-rays and blood results, carrying out peripheral cannulation, arterial blood gas analysis and making certain clinical decisions.
- An early mobilisation programme initiated by the physiotherapy service on GICU, had won a Health Service Journal Value in Health Care Award. This was now carried out on Neuro ICU and had reduced the length of stay in the critical care setting and hospital for patients due to the success of this programme.
- Care for patients across critical care was outstanding. Patients' needs were considered at all times, and a high level of support was provided for the emotional and spiritual needs of family members and patients.
- The critical care service worked closely with the palliative care team to provide timely and empathetic support for patients whose conditions would not improve. This service, in supporting decision making, had enabled 200 patients to appropriately enter an End of Life care pathway.
- The success of a respiratory education package developed by the education team aimed at the full multidisciplinary team had resulted in it being adopted trust wide.
- Neuro ICU worked closely with manufacturers to support development of service specific equipment. This included working with an overseas company to develop and improve intracranial pressure monitoring equipment and working with the provider of lateral rotating beds for patients with spinal injuries to best meet the needs of patients and reduce risk of injury of staff during complex moving and handling procedures for these patients.
- In Neuro ICU, the mobile head CT scanner had reduced the need for patients to be transferred across the hospital, out of hours, for CT head scans.
- University Hospital Southampton NHS Foundation Trust is the only UK hospital providing intraoperative radiotherapy.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust MUST:

- Reduce the number of mixed sex accommodation breaches in the acute surgical unit to improve privacy and dignity for patients.
- The trust must ensure medicines are always stored at temperatures that ensure their effectiveness.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

| Service                            | Rating  | Why have we given this rating? |
|------------------------------------|---|--------------------------------|
| Surgery                            | Good         |                                |
| Critical care                      | Outstanding  |                                |
| End of life care                   | Good         |                                |
| Outpatients and diagnostic imaging | Good         |                                |

# Southampton General Hospital

## Detailed findings

### Services we looked at

Surgery; Critical care; End of life care; Outpatients and diagnostic imaging;

# Detailed findings

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## Background to Southampton General Hospital

Southampton General Hospital is the trust's main hospital for delivering acute services to the population of Southampton and south Hampshire, including some patients from the Isle of Wight.

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.

Southampton General Hospital had a comprehensive inspection of all services in December 2014 and January 2015, and at that time, the hospital was rated as 'requires improvement' overall.

This inspection was a follow up to our inspection of 2015, when the trust was rated as 'requires improvement' overall. This inspection focussed on services rated as 'requires improvement' at that time: surgery; critical care, end of life care, and outpatients and diagnostic imaging. We did not inspect urgent and emergency care, medicine, maternity and gynaecology, or services for children and young people.

## Our inspection team

The team included CQC inspection managers, inspectors and support staff, and a variety of specialist advisors including: surgical consultant; surgical nurse team leader;

critical care consultant, critical care specialist nurse, end of life care consultant and specialist nurse, outpatients nurse team leader; diagnostic consultant, radiographer; and two board level directors.

## How we carried out this inspection

Prior to the inspection, we reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust. We requested and obtained feedback and overviews of the trust performance from local Clinical Commissioning

Groups and NHS Improvement, and this provided information to further inform the inspection planning. We also held a focus group to meet with staff and managers at this time.

We carried out the first part of our inspection between 25 and 27 January 2017 and returned to visit some wards,

# Detailed findings

units and departments unannounced on 7 February 2017. During the inspection we visited a range of wards and departments within the hospital and spoke with clinical and non-clinical staff, patients, and relatives.

We held drop-in sessions for staff to attend, and encouraged feedback to us by email and conversation while we were onsite.

We spoke with 40 patients, carers and relatives in the wards, units and departments. We also spoke with 219

staff across the services. We reviewed 24 patient records as part of this inspection. We observed how people were cared for, talked with carers and family members, and reviewed care and treatment records.

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

## Facts and data about Southampton General Hospital

- The trust is a major centre for teaching and clinical research.
- The trust has approximately 1,372 beds, over 10,000 staff, and over 1,000 volunteers.
- Deprivation in the City of Southampton is higher than average (79 out of 326 local authorities). The surrounding areas of Eastleigh, Fareham, New Forest and Test Valley are less deprived.
- The University Hospital Southampton NHS Foundation Trust provides a wide range and complexity of general and specialist services to 1.9 million people living in Southampton and south Hampshire.
- The trust also provides specialist services to over 3.7 million people in central southern England and the Channel Islands.
- The observed standardised hospital mortality indicator (SHMI) between October 2015 and September 2016 was 95.13. This was within the expected range for patient mortality.

## Our ratings for this hospital

Our ratings for this hospital are:

|                                    | Safe | Effective | Caring      | Responsive           | Well-led    | Overall     |
|------------------------------------|------|-----------|-------------|----------------------|-------------|-------------|
| Surgery                            | Good | Good      | Good        | Good                 | Good        | Good        |
| Critical care                      | Good | Good      | Outstanding | Good                 | Outstanding | Outstanding |
| End of life care                   | Good | Good      | Good        | Good                 | Good        | Good        |
| Outpatients and diagnostic imaging | Good | Not rated | Good        | Good                 | Good        | Good        |
| Overall                            | Good | Good      | Outstanding | Requires improvement | Good        | Good        |

### Notes

# Detailed findings

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. Responsive is rated as requires improvement overall because responsiveness of urgent and emergency care and children's services required improvement in 2015. The services were not re inspected in 2017 as were overall Good in 2015.
3. Caring is rated as outstanding trust wide based on ratings from inspections in 2015 and 2017. Children and young people's services were outstanding for caring in 2015, and critical care in 2017.

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|                |             |   |
|----------------|-------------|---|
| Safe           | Good        |  |
| Effective      | Good        |  |
| Caring         | Good        |  |
| Responsive     | Good        |  |
| Well-led       | Good        |  |
| <b>Overall</b> | <b>Good</b> |  |

## Information about the service

The surgical services at the Southampton General Hospital are provided across all four divisions, mainly in Division A and Division D. The services provided included general surgery such as elective orthopaedics, trauma, head and neck surgery, vascular, urology, upper and lower GI and ophthalmology, and specialist neuro surgery, spinal and cardiothoracic surgery.

There are preoperative assessment clinics, day surgery units and 27 theatres supporting the surgical activity.

Between April 2015 and March 2016 the surgical patient spells (the stay of a patient using a hospital bed) were 36,907. This was divided between 36.3% day cases, 28.2% elective or booked admissions and 35.5% emergency patients.

This was a responsive follow up inspection after the announced comprehensive inspection in 2014. Following that inspection surgical services were found to 'require improvement' in the safe and responsive domains, which meant that surgery was rated as requires improvement overall.

During this inspection we spoke with 24 patients individually, 160 staff both individually and in groups. We reviewed 12 patient records in depth. We visited over 19 different clinical areas at various times over the two and a half day inspection.

## Summary of findings

We rated this service as good because:

- There was clear, accessible and visible strong leadership at a senior and local level. Surgical teams had strategies for development and improvements that linked into neighbouring trusts.
- The trust had a well-established reporting structure, with clear processes for learning and sharing from incidents. The governance structure clearly fed into central trust governance meetings. There were local risk registers in place and staff were aware of their highest risks and taking action to manage or reduce these.
- Regular morbidity and mortality meetings reviewed care processes and unexpected patient deaths for learning and shared any findings.
- The trust delivered care based upon national evidence and had policies and guidance that were updated as national guidance changed.
- There was a good preoperative assessment process for booked elective admissions, which included a consultant anaesthetist presence, online protocols for guidance of the nurses undertaking the assessments. There were excellent examples of multidisciplinary working in surgical teams.
- There was an acute pain team to support patients and staff. Recent developments in pre-loaded pain relief prescriptions to the electronic prescribing system prevented delays in the administration of pain relief.

# Surgery

- Theatres had developed a new safety checklist 'Stop Points for Safety' following active engagement from staff using the National Safety Standards for Invasive Procedures (NATSSIPs) programme. The procedures for anaesthetic emergencies in theatre were clear to staff.
- The trust's performance in referral to treatment times was better than the England average. The surgical teams worked across 7 days, with consultant cover 7 days per week.
- The day surgery services were flexible in opening times, patient case mix and supporting patient flow through the hospital. Patients attending day surgery were given pagers so they did not have to wait in a crowded waiting room. Recovery were able to discharge low risk patients direct from recovery to maintain patient flow. There was a new surgical discharge lounge for six patients.
- Team handovers were fully inclusive, in depth and professional at all levels.
- The trust was actively developing alternative roles to try to address its significant recruitment challenges. Staffing levels were assessed regularly and senior teams shared the staffing resource based upon acuity and patient needs. There were mealtime coordinators to ensure the prompt delivery of food to the patients.
- There were significant registered nurses vacancies in some surgical care groups, and the trust was actively managing the risks.
- Staff were encouraged to continue their professional education. To allow for education and development to take place, there were regular rolling shutdowns in theatre.
- There was good, safe medicines management in wards and theatres. Regular checks of controlled drugs were taking place.
- The wards were visibly clean with good infection control processes and widespread use of 'I am Clean' stickers providing patient reassurance.
- Throughout our inspection staff were caring and passionate about giving good patient care. They were excellent patient advocates. Some staff who had two or three language skills had trained to be interpreters to prevent delays in gaining consent.

- Staff upheld patients' privacy and dignity whenever possible. There was enhanced care support for the wards to provide support and guidance with patients with challenging behaviour. There was timely and accessible psychiatric support for older people and for adults.

However:

- The trust had investigated four 'Never Events' in surgery between November 2015 and December 2016.
- Performance in hip fractures was not achieving the national standards in some areas. Hip fracture patients stayed four days longer in the trust than the national average, although new local data showed improvements.
- The records storage trolleys in the majority of wards were open topped, which potentially left records containing patient identifiable information at risk. A risk assessment had been undertaken, and the risk had been mitigated to some degree by the trolleys being stored close to the nurse's stations in plain sight.
- Patients risk assessments were not all reassessed following surgery or weekly as per policy. Turnaround charts for the record of regular care and attention to patients were not always completed. Signatures in records were illegible and signature were not printed underneath.
- There were delays in obtaining pressure-relieving mattresses. There were delays in ward repairs so some facilities were out of use for a considerable time.
- There were few patients' facilities that were gender specific. Patients were not able to consistently access clearly labelled gender-specific toilet and bathroom facilities as arrangements were not consistently implemented.
- Some single sex breaches had taken place in ASU.
- There were some negative comments from patients relating to the standard of food. Staff told us there were insufficient meal delivery trolleys to deliver hot meals.
- Some senior staff told us they had not had Mental Capacity or Deprivation of Liberty Safeguards training.

# Surgery

## Are surgery services safe?

Good 

We rated safe as good because:

- There was a reporting structure, with clear processes for learning and sharing from incidents.
- There was safe medicines management in wards and theatres. Regular checks of controlled drugs were taking place.
- There was a good preoperative assessment process for booked elective admissions with included a consultant anaesthetist presence, online protocols for guidance of the nurses undertaking the assessments.
- The wards were visibly clean with good infection control processes and widespread use of 'I am Clean' stickers for patient reassurance.
- Theatre had developed a new safety checklist 'Stop Points for Safety' following active engagement from staff and using the National Safety Standards for Invasive Procedures (NATSSIPs) programme.
- The trust was actively developing alternative roles to try to address its recruitment challenges.
- The trust assessed staffing levels regularly and shared the resource based upon acuity and patient needs.
- The handovers witnessed were fully inclusive, in depth and professional at all levels.
- There had been efforts to reduce the number of open or in progress calls for repairs to equipment.
- There was a system for the indication of safety testing, with a colour coding system for each calendar quarter which was developed following the last CQC visit inspection.

However:

- The trust had investigated four 'Never Events' in surgery between November 2015 and December 2016.
- The records storage trolleys in the majority of wards were open topped, which potentially left records containing patient identifiable information at risk. A risk assessment had been undertaken, and the risk had been mitigated to some degree by the trolleys being stored close to the nurse's stations in plain sight.

- Patients risk assessments were not all reassessed following surgery or at the weekly reassessment as per policy. Turnaround charts for regular nursing reviews were not always completed.
- Some medical signatures in records viewed were illegible and printed signatures were not always included.
- There were delays in obtaining pressure-relieving mattresses, which left some patients at risk, although the outcome data did not show this.
- There were delays in ward repairs so some facilities were out of use which impacted on patients.

### Incidents

- Between November 2015 and December 2016, the trust reported four incidents, which were never events for surgery. These were four unrelated events in different theatres, which the trust reported, thoroughly investigated with outcomes and learning points identified. 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.
- The trust reported 19 serious incidents (SIs) in surgery, which met the reporting criteria set by NHS England between November 2015 and October 2016. Of these, the most common types of incident reported were; pressure ulcers meeting SI criteria (five). SIs were discussed at monthly clinical governance meetings with specific actions and learning fed back to staff as part of the investigation process.
- The trust supplied data, which showed that surgical teams reported 285 incidents classed as 'near misses' between January 2016 and December 2016. There were 2056 incidents reported in this period. The top five incidents reported were (the highest first) medication incidents, staffing, slips trips and falls, care, and communication.
- Divisional teams described processes to share learning points following incidents, and gave examples of changes to practice because of incidents, for example, six incidents in 2016 had led to a change of the theatre team brief and checklist. The trust held an educational event to discuss the issue and changes took place after agreeing potential solutions. The trust was using a 'Stop

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Points for Safety' protocol instead of the World Health Organisation Five Steps for Safer Surgery using the National Safety Standards for Invasive Procedures (NATSSIPs) programme.

- Staff we spoke with told us that incident reporting was encouraged and reported electronically. Feedback from incidents took place at ward and department handovers or meetings and on staff notice boards.
- Theatres had a communication book in the day surgery unit, they had a weekly theatre bulletin called 'Hawkeye', which provided feedback, and any safety alerts regarding equipment. We saw a recent one displayed on the theatre wall, which had 'learning after an event' section. There were details regarding the use of suction following an incident.
- Mortality and morbidity (M&M) meetings took place in each care group or speciality; medical teams attended the M&M meetings, although a few were multidisciplinary. The meetings had minutes recorded and discussed the care of patients, which had not gone to plan or if there had been an unexpected death. The M&M chair circulated any identified learning points to the whole team.
- 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. The trust monitored duty of candour through their online incident reporting system. The duty of candour requirements were well embedded as the staff we spoke to confirmed that they knew and understood the process.

## Safety thermometer

- The safety thermometer data recorded the prevalence of patient harms nationally and provided immediate information and analysis for ward teams to monitor their performance in delivering harm free care. Teams focussed their attention on the reduction or elimination of patient harm.
- Data from the patient safety thermometer showed that the trust reported 24 new pressure ulcers, 22 patients falls with harm and 27 catheter urinary tract infections (CUTI's) between November 2015 and October 2016.

Over the year, pressure ulcer incidents had shown a downward trend and had averaged below one a month over the last four months. Patient falls and CUTI's both remained at around two per month.

- The clinical quality dashboards displayed their local safety thermometer data, the risk coordinators received the data to display by the senior ward staff. This included pressure ulcer prevalence, venous thrombosis or blood clot events and infection control compliance.
- We saw variability in ward safety displays, with some wards showing this information, others not. Some wards had low scores reported for some data compliance but when questioned the ward sister informed us that the data was not correct. Some wards had information displayed that was out of date. There was no standard ward information and some wards had no access to colour printers, which made the black and grey printouts extremely difficult for the public to understand. We raised this with the trust at the inspection who took action to rectify the situation.

## Cleanliness, infection control and hygiene

- The trust monitored the divisions for compliance against MRSA policy standards when a patient acquired MRSA whilst an inpatient. The trust divided them into patient management standards prior to a result being obtained and prevention of spread standards after the result. Between July 2016 and December 2016, Division A had five cases of newly acquired MRSA and Division D had seven. Division A was 100% compliant with the patient management standards and 58% compliant with the prevention of spread. Division D was 29% compliant with the patient management standards and 88% compliant with the prevention of spread.
- The trust monitored the care of patients who had C.Difficile toxin positive cases acquired in the trust and in the community using policy standards. Between July 2016 and December 2016 Division A monitored 14 positive patients and achieved 63% compliance. Division D monitored four positive patients and was 50% compliant against the trust standards. The standards included patient isolation within two hours and the use of correct hand hygiene.
- The trust screened pre-operative patients for MRSA; and gave every patient special solution for washing and showering. If the patient was a positive MRSA there was a standard 12 week treatment course prior to surgery.

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The team would re swab, if there were delays to a patient's surgery. The trust treated new MRSA positive patients as positive for six months after the initial positive result.

- The trust had identified itself as a slight outlier for elective orthopaedic infections; however they operated on slightly older (over 80 years) and therefore higher risk patients. The length of surgery was seen as a contributory factor and was stated as taking 4% longer than nationally.
- The published rate of infections in knee joints was 1.9% against a national average of 0.5%, however new unpublished rates show that the trust has reduced the incidence to 0.4%. The trust investigated all wound infections for themes and types of organisms and identified actions for changes to practice.
- Throughout the surgical wards, we saw adherence to 'bare below the elbows' by all staff. There were hand gels outside of most patients rooms, with hand washing information displayed.
- Where patients were isolated for the prevention of cross infection, we saw the appropriate use of personal protective equipment and signs advising staff and visitors, with an appropriate closed door. We saw the ward staff use a prompt and effective infection control response to a potential infection within a ward, with support from the infection control team.
- Ward staff we spoke with told us that the infection control team did spotlight ward audits in cleanliness throughout the year. There were identified infection control link nurses on most wards and departments with relevant training.
- Some areas had a sepsis information board with clear poster information for staff and patients. We did not see any infection control notice boards with the results of audits such as hand hygiene, ward cleaning checklists or the spotlight audits by infection control.
- We saw that in general, the wards were uncluttered; most had storage areas for equipment although there were a few exceptions when wards had been relocated. Clean linen was stored appropriately in closed cupboards. Linen disposal guidance was clearly displayed in dirty utility areas.
- There were waste bins for clinical and domestic waste on the wards and departments. However, anaesthetic rooms had open topped colour coded bins, staff did not change the liners between patients and they had no lids

to prevent cross infection between cases. The trust provided evidence and assurance that the process had been risk assessed, and patients were not exposed to cross contamination.

- Staff cleaned equipment after each patient and the use of 'I am clean' stickers. The ward staff cleaned pressure-relieving mattresses, and the supplier decontaminated them after collection.
- The wards were visibly clean; some of the corridors and doors were not so clean but we saw a large number of people using them. Wards had cleaning checklists, which the housekeepers completed. We saw the majority were completed every day, and were audited by the cleaning company as mostly 100% compliant.
- There were night cleaning jobs allocated to the nursing staff. However, we saw some commodes and equipment not tagged as clean so it was unclear if they were clean or not.
- We saw that most sharps bins were signed when put together and had lids, they were not overfilled as per policy.
- In ophthalmology theatre, equipment was taken away to the central sterile stores for decontamination, the team were able to turn equipment around quickly as a priority if need be. Patients who were having cataract surgery went into theatre in their own clothes, there had been no infection issues and it was felt to be less traumatic for the patients.
- In theatres we saw one anaesthetic machine with a split tray, which was taped with surgical wound tape. This would not be able to be cleaned effectively. A drip stand was held together with sticking plaster, which also would not be able to be cleaned effectively. In a storage area for non-sterile instruments kit in theatre was seen to be very dusty on the floor and on the storage trolley. These issues were shared with the theatre matrons at the time of the inspection.

## Environment and equipment

- The trust provided information on the response times for repairs, with examples given from the theatre complex. There were 33% of repairs resolved in less than 24 hours, 25% of repairs resolved in between 24 hours and a week. 29% of theatre repairs took between a week and three months to resolve. There were over 9% of repairs, which took between three, and twelve months

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to resolve and 3 % which were still unresolved after 12 months. We saw improvement in the number of open calls. There were fewer than 1000 in January 2017 from over 3500 in March 2016.

- Whilst on inspection we saw visible delays in the repair and maintenance of ward facilities with 'out of use and awaiting repair' signs, for example one ward bathroom had been out of use for 'months' as the emergency alarm was not working. Another area was using temporary call bells due to electrical circuit problems. One ward reported a patient toilet and washroom out of use at the end of December 2016 and it was still awaiting repair. In another ward two showers were out of use, due to a risk of flooding, this forced patients to utilise facilities in other patient bays specific to their gender.
- In general, we saw most wards were in a good state of repair with well-spaced beds, and adequate toilet and washing facilities. Most had sliding male/ female signs. There were few patients' facilities that were gender specific, and patients were not able to consistently access clearly labelled gender- specific toilet and bathroom facilities as arrangements were not consistently implemented.
- Some wards shared shower facilities with the ward next door, which were not gender specific.
- We saw piped oxygen and suction points in each patient's bed space in most surgical wards, where there was a shortage of points this had been risk assessed.
- We saw that most ward sluices had non-secure doors, in some; detergent and urine dipsticks were left out on worktops. We visited ten different surgical wards, and of those, two of them had cleaning cupboard doors left ajar in the main ward corridor.
- We saw in all areas that there should be a daily emergency check of the resuscitation trolleys, and in E8, E5 and E neuro wards, ward checks were seen to have occasional gaps in their daily recorded checks.. Trolleys in ward areas were fitted with tamper proof tags, and had a weekly check of the contents for expiry dates.
- The operating department practitioners (ODPs) checked their anaesthetic equipment, the anaesthetist made a further check prior to the list starting.
- Within theatre anaesthetic rooms, some of them had emergency bells installed and some had access to a phone to call for emergency help. There were clear posters on how to obtain help and the numbers to call, and staff were able to signpost what to do.
- There was an adult and paediatric "difficult intubation" trolley held centrally within each of the theatre complexes, and within satellite units. A named consultant anaesthetist was responsible for them and the equipment was standardised and based upon 'difficult airway society' guidelines. The ODPs checked the trolleys daily and signed off as completed.
- The clinical engineering department managed the medical equipment at the trust. There was an annual process for replacement equipment or to lease as equipment became out of date. There was a bidding process for new equipment through business cases.
- The equipment library provided open access in hours, staff accessed it via a key out of hours. The trust had a contract for the supply of pressure relieving mattresses via an external company. Staff we spoke with told us of numerous delays in obtaining mattresses for patients assessed at risk of developing or with a pressure ulcer, the trust was aware of the issue. Some waits were as long as three days, which staff reported as incidents. However, the eye department reported that they often had mattresses awaiting return for up to two weeks.
- The trust provided the response times for issuing requested pressure relieving mattresses for patients at risk of developing a pressure ulcer. This illustrated that 22.7% of mattresses were issued within two hours, 48.6% were delivered between two and 24 hours. There were 24.2% requests that took over 24 hours, potentially placing the patient at risk.
- Some areas stated there was not enough equipment, describing how their equipment moved to other areas of the hospital. However, the majority of surgical wards were seen to have adequate equipment, one ward told us they had recently received seven new blood pressure recording machines, patient chairs, bedside tables and patient scales.
- The trust had purchased new surgical drip stands recently with red bases for easy identification and potential return. The staff told us that bariatric equipment was available for patients whose weight may be detrimental to their health, and was appropriately in use on the wards.
- The trust had developed a system for the indication of safety testing, with a colour coding system for each calendar quarter following the last CQC visit inspection.

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It was well-communicated to staff within the trust and accredited to ISO 9001 : 2008 which meets key recommendations of Medicines and Healthcare products Regulatory Agency (MHRA)

- The trust data showed that there was a robust servicing process linked to the asset numbers, which wards audited annually. External companies serviced most equipment, overseen by the equipment team. In theatres, asset tags tracked equipment and labels showed when servicing was due. The medical equipment team organised annual servicing and safety checks during down times, for example the education sessions when theatres were mostly not in use.

## Medicines

- The trust used an electronic system for prescribing medicine and recording administration, the majority of staff we spoke with said they felt confident in the system and preferred it. Registered nurses wore red tabards to show that they were involved in medicine administration rounds; as interruptions can cause missed medicines and delays in pain relief.
- Patients all wore appropriate identification bands, which nurses checked when administering medicines. We observed the name signs above patients' beds were not always up to date with the patient's name.
- Medicines within wards were stored in locked cupboards within locked rooms accessed by keypads. Wards locked medicine fridges and daily monitoring of most fridge temperatures were within the acceptable range. There were no medicines fridges in anaesthetic rooms; all medicines needing refrigeration were stored in the central pharmacy room in theatre.
- The wards locked and secured mobile medicines trolleys to a wall. In one ward, we saw a trolley with the record open and unattended; however, a member of staff rectified this immediately.
- Controlled drugs (CDs) were stored a locked cupboards with the keys held by the nurse in charge.
- Ward CD checks were completed twice weekly by night staff. ODPs checked CDs within anaesthetic rooms at the start of the operating list and at the end, plus if the ODP changed in the middle of the list. We saw anaesthetic emergency drugs drawn up and labelled ready for use.
- We saw that intravenous fluids were stored in locked cupboards. Medical gases were seen mostly stored appropriately in wall brackets.

- The trust used patient controlled analgesia (PCAs) infusions for pain relief for some patients, we saw staff checking and preparing the syringes appropriately for the infusions. All recovery staff were trained and competent in this setting up and managing PCA infusions, epidurals and local anaesthetic block infusions.
- We witnessed staff making efforts to align intravenous medications to prevent multiple disturbances for the patient overnight.

## Records

- The trust had a mix of electronically generated records and paper records. For example, theatre operation notes, anaesthetic records and patient prescriptions were electronic and a copy printed out for the records. The remaining records were all in paper form.
- Staff chose the patient admission records according to the patient's potential length of stay and complexity of their surgery. All paper records were kept together in one folder.
- Most wards we visited there were open trolleys for patient record storage. These were located at the central nurses' station, in plain sight close to the ward clerk. The trust informed us that record storage had been risk assessed.
- We saw in a day case areas records were unsecure in open corridors; we raised this as a concern to the senior management team. Following our visit, staff explained that a risk assessment was done before the unit opened and the risk would be tolerated. Because of 50 + patient admissions per day, local accessible records were of extreme importance and outweighed the risk of security. Staff were always present and the records accompanied patients to theatre. The unit locked records away securely at night.
- Theatre logbooks were completed correctly. In the anaesthetic rooms, there was a newly developed daily equipment checklist, which the ODP completed and signed. This included for example, tasks such as circuit changes, restocking, and CD checks. We saw that in all rooms we looked at that these were fully completed.
- Records that we inspected were seen to include an in depth preoperative assessments, risk assessments of pressure ulcers, nutrition, and falls, medicines records, and electronic operation records. There was a paper print out of the electronic observations and a fully

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completed consent form. We saw where patients had been risk assessed these were appropriately acted upon. However, we saw some that had not been re-assessed following their surgery and risks updated.

- Care plans were standardised within the main nursing record booklet and were reviewed and evaluated daily with add in evaluation sheets, most were seen to be completed and evaluated.
- Most patient records were complete with legible records; however, signatures were overall illegible with no printed version underneath. There were some staff signature lists to enable identification of the signatures, but the trust told us these were not mandatory
- We also saw white planning boards in the ward corridors with individual patients' names visible to the public, there were codes used for progress. Ward staff asked patients for their consent to display their name on admission.

## Safeguarding

- The trust delivered safeguarding and mental capacity training face to face and on line for level three over one day. The trust assessed and decided the required levels of safeguarding and child protection training against staff roles. The trust target for child protection level 1 and 2 was 85%; the surgical care groups had achieved an average of 88.6% and 72.5% for each level.
- The safeguarding adults training compliance was an average of 72% compliant across all groups of staff.
- The trusts' educational key performance indicators showed that child protection level 3 was red at only 17% compliant and only one of the six staff who required it compliant. The trust did not tell us of any specific actions being taken to raise this compliance. However, since the inspection the trust has clarified its staff training requirements and confirmed that only three staff were required to be trained to this level and all had been trained.
- Senior paediatric nurses gave lectures on signs and behaviour to look for to safeguard children.
- Ward staff had access to the 'How To' folders which contained details of safeguarding processes. There were posters on display illustrating the needs and complexities of vulnerable adults.
- Most staff we spoke with had a good understanding of the process of safeguarding. Staff knew where to go to obtain help or more information.

## Mandatory training

- The trust told us there had been a new online system known as the virtual learning environment, (VLE) for mandatory training, but there had been many technical issues. The trust was not sure that the data provided by the system was reliable and completely accurate.
- Trust new staff received an induction, which included mandatory training; the compliance for this was 90.5%. There were 12-14 components to mandatory training depending on staff roles, which trust staff were expected to complete, for example fire safety, hand hygiene and information governance.
- The trust target for mandatory training compliance was 85%. The trust data for the year up to January 2017 showed the lowest compliance for mandatory training in surgical staff was in prevent (terrorism identification training) at an average of 66.3% compliance. The highest compliance for surgical staff was an average of 90.5% for hand hygiene. The information governance target was 90% due to national requirements and the compliance for surgical staff was 72.5%.
- The trust data showed the worse compliance for mandatory training was amongst surgical medical staff who achieved between 54% and 82.8%, none of which was at trust target. The senior surgical teams were encouraging their staffs' compliance.
- Ward and department senior staff told us that on line training had not been recording properly for some time; therefore, they were unable to see their staff training records. Staff were having mandatory training but the data collection was an issue, appraisals were used to check staff compliance. Senior staff manually checked mandatory training. As a 'work around' the education team were keeping records and booking training courses.
- Theatre staff were given time when theatres were quieter to do training, for example at weekends, there were plenty of computers to access training within theatre. Staff were also given time back if they did training in their own time.

## Assessing and responding to patient risk

- The trust policy was for pre-operative assessment (POA) for most planned surgical patients. For example patients who were to have a general anaesthetic, and for patients having a local anaesthetic who were taking new anticoagulants (blood thinning medicine). The majority

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of over 1000 patients assessed per month were with face-to-face interviews. The POA team telephone assessed low risk or simple cases. POA was usually a nurse led assessment, however for patients assessed as high risk this was with a consultant anaesthetist. There were guidelines as to which patients must be seen by an anaesthetist. For example, all patients for hip and knee replacement surgery had to see the anaesthetist, but the POA nurse referred knee arthroscopies if required. A preoperative pregnancy test was only done if required.

- However, we witnessed a patient cancelled for theatre who was given unclear instructions about stopping their warfarin (blood thinning medicine).
- An intensive care consultant anaesthetist performed the preoperative medical review, they were based in the preoperative assessment unit for between nine and ten sessions Monday to Friday. They assessed high-risk patients for their fitness for surgery by undertaking a thorough physiological assessment of the patient. This was to predict their need for a critical care bed postoperatively. The lead anaesthetist was responsible for the POA protocols based upon the grade of surgery and comorbidities of patients.
- We saw patients having thrombo prophylactic stockings applied on the surgical wards prior to their operations if their preoperative risk assessment for blood clots or venous thrombo embolism (VTE) was high.
- The surgical specialties compliance for VTE risk assessment on admission over the past 12 months varied, the standard was for 95% of patients to be risk assessed. The numbers of admitted patients VTE risk assessed varied each month between the lowest number at 87% in December 2016 and the highest number of 94% in January 2016.
- The trust ran emergency or CEPOD theatre lists daily for emergency surgical admissions. 'Golden patients' or first on the list patients were identified and prepared for surgery first so that lists started on time. There was flexibility to open up more theatre space if needed for extra emergency patients; staff said this happened about once a week.
- Theatre lists were changed sometimes, and theatres phoned through changes to the wards. The wards changed the list; theatres did not issue new lists. The most up to date theatre lists were on display in theatres and in the anaesthetic rooms.
- The theatres team used warming mattresses and pressure pads under patient's heels to prevent pressure

ulcers. Pillows were placed under the patients legs and air pressured boots were used to prevent venous thrombosis (blood clots). A temperature probe was placed in the patient's nose. This was for accurate recording of temperatures intra operatively every 30 minutes to ensure their temperature was above 36° centigrade. This was one of the recommendations of the national 'Saving Lives Care Bundle' guidance to prevent surgical site infections and within the NICE CG65 recommendations.

- We witnessed care and good team work in the head placement for protection of the patient's airway and allowing access for the surgical procedure.
- The trust had audited the previous World Health Organisation's Five Steps for Safer Surgery checklist in 2016, within the different speciality theatre teams using self and observed auditing tools. The combined results showed that for the team brief they were 94-97% compliant. For sign in compliance ranged from 93- 98%, for time out 79-100% and for sign out between 53-95% compliant.
- The trust had recently developed a new surgical checklist as a response to the National Safety Standards for Invasive Procedures (NATSSIPs) programme. Across theatres, there were laminated information sheets on its use. The new checklist known as 'Stop Points for Safety' incorporated three stop points which allowed for a team brief at the start, a time out immediately prior to surgery and a sign out at the end. We observed its use by many different teams, each time all staff engaged, had stopped, and were actively listening. Staff were able to make a query and different issues discussed such as the patients' thrombo-prophylaxis (to prevent blood clots) and antibiotic use. We also witnessed the checking by the theatre team of patient ID, consent, marking and patient allergies before making the first incision.
- Theatres were about to audit the new tool, as it was a new process and results would be fed back to teams as part of the change process.
- Wards planned to reassess patients' safety risks every week, patients with high risks were re assessed more often. For example, a risk assessment for the use of bed rails on a patient's bed was regularly re assessed. However, we saw in some records that re assessments had not happened weekly as per trust policy.
- Nurses used a combined document to record patient's vital signs and pain scores, which, depending on the results calculated and provided a national early warning

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score (NEWS). This alerted the staff of the patients' deterioration and gave specific actions to follow when the score increased. Ward patients whose scores were escalating, were referred to the outreach team or to a surgical doctor. The staff also used a sepsis-screening tool with an escalation flow chart. We witnessed the appropriate escalation of a patient to doctors following a rise in their NEWS score.

- Staff used the situation, background, assessment and recommendation (SBAR) tool to ensure that any communications of escalations were effective.
- The staff described the outreach team as very skilled and approachable. They gave initial advice over the phone, and followed up in person later. Staff found them particularly useful for patients admitted following resuscitation in ED.
- If a patient in recovery required additional medical support, escalations went to the anaesthetist. For patients in the day surgery unit, staff called on recovery staff and anaesthetists for support who were located just across the corridor.
- Staff identified patients with differences in lying and standing blood pressure as at a risk of falling. For patients assessed as high risk of falls, staff used a variety of equipment to try to prevent a recurrence. This included high-low beds and alarmed pressure pads.
- Wards had link nurses for patients living with dementia and some wards had additional equipment to help occupy patients living with dementia. For example an activity corner with history and music to stimulate the patients and to reduce the risk of wandering and potentially falling due to little stimulation.
- Ward staff assessed patient acuity daily via the 'safe care' monitoring tool and sent to site managers. Staff used turnaround charts to record regular visits and interventions, if patients were at high risk of falls or pressure ulcers. These charts were not always fully completed.
- A local tool had been designed and was used to assess for risk and to manage pressure ulcer prevention, known as the pressure risk evaluation and skin screening tool 'PRESS'. We saw actions taken after the assessment, for example, a pressure-relieving mattress requested or a turnaround tool used for repositioning. There was a continence team to access for advice in managing patient bowels or bladder and a tissue viability team for help with wounds or pressure ulcers.

- Diabetic patients had regular blood sugar testing whilst in hospital; records we saw showed that these were completed regularly.
- When patients who had self-harmed were referred to mental health teams, they were reviewed quickly, if extra staffing for one to one support was requested, another ward might supply it.

## Nursing staffing

- The trust had faced significant staffing challenges, particularly in recruiting and retaining registered nursing staff. They were developing roles to try to retain recruited staff.
- The trust had recruited and supported overseas nurses from Portugal and Spain. They had received support with their language skills within the trust induction programme. Some overseas nurses wanted to move to theatres or intensive care after two years, in preparation for a return home. The trust was looking at developing internal rotation for overseas nurses to prevent the predicted movement to other trusts.
- The heads of nursing and matrons reviewed ward establishments every six months and adjusted them depending on the wards patients' dependencies or needs.
- The trust had rolled out the 'safe care' element of the electronic rostering system, which was based upon the 'Shelford Model'; patients were assessed up to three times a day.
- Senior nurses monitored wards' staffing levels against the acuity or dependency of the patients and shared them at daily trust wide staffing meetings. Following the trust wide assessment, and using professional judgement, staff were moved or the ward skill mix was adjusted. This provided the trust an assurance of safe staffing overall and matched the needs of the patients.
- The trust data showed that the staff sickness rates for the surgical specialty wards for the period between December 2015 and December 2016 was an average of 4.5%, against the trust target of 3.5%.
- The surgical wards frequently moved staff around to cover gaps, sometimes registered nurses (RNs) were moved and backfilled with a health care assistant (HCA). The ward sister had agreed parameters for working on reduced staffing. Staff we spoke with said it was usually one staff member per shift depending on patients' acuity. We witnessed a ward offering up staff that were no longer needed.

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- Most wards and departments displayed their daily planned and actual staffing numbers for public viewing. Sometimes the skill mix was adjusted to reflect the dependency of the patients, but we saw the majority of shifts were covered as planned. Additionally ward clerks, housekeepers and supernumerary student nurses on placements supported wards.
- One ward sister described having 5.8 RN whole time equivalent vacancies, but was being supported by other surgical wards. Sisters told us that they should be supervisory but due to ongoing staffing gaps, it was not possible, their vacancies had proved hard to fill with bank nurses.
- We witnessed a senior nurse in detailed planning, allocating staff for patient care, organising breaks and covering potential gaps. The senior nursing team agreed a request for an agency nurse to support the ward.
- The trust data showed the surgical wards had vacancies of 28% in registered nurses, neurosciences wards 20%, cardio thoracic and vascular wards 12% and 19% in trauma and orthopaedic wards and 9% in theatres. In the women's surgical wards, there were 6% RN vacancies.
- The trust was in the process of appointing new Band 4 associate roles to try to supplement the registered nurse shortage. Nurses told us the trust had just recruited them when we inspected and most wards would have one.
- The three highest vacancy rates for individual surgical speciality wards were ward F1 (trauma) at 30.8%, the acute surgical admissions unit at 27.7% and E5 upper gastrointestinal ward at 23.4%.
- Wards with the highest turnover rates were the acute surgical unit at 31.5%, ward F5 with 28.4%, and the acute surgical admissions unit 24.7%. Trust data showed a corresponding high amount of bank and agency usage in these areas to fill and therefore reduce the staffing gaps.
- The day surgery unit (DSU) told us they did not normally have a problem with staffing, nurses covered gaps in the rota by working extra shifts or the internal bank supplied nurses.
- We spoke with bank nursing staff who confirmed that they had received a local induction to the ward. We saw completed signed induction checklists stored in order. The bank employer assured the trust of the bank staffs' competency and mandatory training.
- The wards used 'specials'. A special is an extra staff member to provide one to one care for challenging patients to prevent them from harm, for example patients who had previously fallen and were at risk of further falls or a patient living with dementia who wanted to wander freely and needed an escort to keep them safe. There was an 'enhanced care team' who provided support in planning the care of these challenging patients, staff we spoke with valued their advice and support with patient management.
- The trauma unit had eight advanced nurse practitioners who supported the trauma wards from eight am until eight pm; they provide specialist trauma support to patients, nurses and to junior medical staff.
- The senior trauma and orthopaedic team highlighted issues in the inability to recruit plaster technicians. The team had 'over' recruited trainees to reduce the impact of the staff being trained and leaving for other trusts.
- We witnessed as many different handovers as possible whilst we were inspecting, and were impressed by the professionalism and the depth of knowledge and care that the staff displayed. They were fully inclusive and thorough, discussing all areas of patient care including nutrition, pain control, patient risks and discharge planning. Most wards had a face to face team handover at the patients' bedsides with the coordinators ward handovers taking place in the office.
- We saw white board rounds, these took place in corridors and nurses stations; we saw that it was difficult to maintain patient confidentiality due to the placement of the boards.

## Surgical staffing

- The trust had 527 medical staff employed within the surgical care groups. There was the same proportion 44% of consultants and 44% registrars within the skill mix working in the surgical care groups.
- Compared to the England average of 36%, there were more registrars in post within the trust, the consultants were slightly above the England average of 43%. However, there were a small proportion of junior doctors in training 8% and 3% of middle grade doctors, which were less than the England average of 10% for each group.
- The trust stated they had no vacant consultant posts, and low level of middle grade or registrar vacancies. The

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trust recruited into research and educational posts to support the rotas. An internal medical bank optimised permanent staff or recent employees to cover any vacant shifts.

- Between February 2016 and January 2017, the surgical care groups used 22% of bank and locum medical staff. The trust data showed the highest use of agency and locums were in the ear, nose and throat care group peaking at 31.1% in April 2016. However, this had reduced down in November 2016 to 11.8% and was 3.9% in January 2017.
- All acute surgical care groups had consultant cover across the whole 24 hour period; there were five acute surgical unit (ASU) consultants who shared the cover. There was always one dedicated to the ASU, with a consultants ward round taking place seven days a week.
- We attended the daily surgical morning handover in the ASU, which consultants, registrars, junior doctors, nurse practitioners and the surgical pathway manager attended. We witnessed good handover of information within a multidisciplinary forum.
- One junior doctor was ward based covering GP calls, ED and clinic referrals, for high volumes of patients (up to 35 referrals per day). Staff we spoke with felt this insufficient for the workload and to be able to act and plan patient treatment quickly. However, they did not say that this had been escalated to the senior team.
- Orthopaedics and trauma cover was by the 10 trauma only consultants, who made one in ten weekend cover.
- The registrars provided support to the junior doctors who were on rotation as part of their training.
- Patients confirmed they saw and were reviewed by a doctor every day, although it was 'usually a different one each time'. The trust provided evidence that work had been ongoing in trauma and orthopaedics to improve the patients' experience of ward rounds.

## Theatre staffing

- A consultant anaesthetist and surgeon were the leads for the CEPOD theatre, all ODPs rotated through for experience. A surgeon and an anaesthetist staffed the CEPOD lists between 8am and 9pm. A senior registrar covered the CEPOD list at night but according to clinical need, a consultant was also available to attend.
- Theatre used a live allocation board for staffing allocation to lists, this displayed colour coding depending on whether gaps were filled by bank staff or if there were students or shifts were still to fill. Theatre

staff told us that recruiting to theatre was an ongoing problem; the staff turnover was high with many overseas recruits frequently moving to London. However, they still felt that numbers of vacancies were the best they had been for years.

- Staff working voluntary overtime covered vacant shifts as internal bank staff (mostly regular staff). The trust had specially negotiated theatre bank staff rates, these were slightly higher than normal rates but lower than high rate agencies.
- The surgical first assistant (SFA) had replaced the previously titled advanced scrub practitioner (ASP). This was a nationally recognised change that followed recommendations from the perioperative care collaborative (PCC) in 2012. The SFA was part of the theatre establishment and acted as a first assistant on a planned basis.
- Surgical care practitioners (SCPs) were also in use in theatres, managed by the medical team, and had a new in house Association for Perioperative Practice (AFFF) style training programme and competencies, which were overseen by consultant surgeons. The surgeons sponsored the post holders who were either ODPs or nurses. There were eight in training and eight fully trained.
- Senior staff told us that weekend staffing was a challenge especially to have a dedicated first assistant and a scrub nurse. Theatre staff told us there should always be three individual roles, the SCP, the SFA and the scrub person, if on occasion a planned one is missing then an incident form was raised. The new theatre checklist allowed staff to speak up if they were stressed or unhappy.

## Major incident awareness and training

- The trust's major incident plan (October 2016) applied to all services provided by the trust. Staff we spoke with were aware of the trust major incident plan and their role in the event of a major incident.
- As a major trauma centre, the surgical teams had well developed plans for major incident procedures.
- A recent major incident practice identified that the day surgery unit would be used as a decant unit for trauma patients. This would then enable the trauma wards to be ready for the new admissions.

## Are surgery services effective?

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Good



We rated effective as good because:

- The trust delivered care based upon national evidence and had policies and guidance that were updated as national guidance changed.
- The acute pain team supported patients. Recent developments in pre-loaded pain relief prescriptions to the electronic prescribing system prevented delays in the administration of pain relief.
- There were mealtime coordinators to ensure the prompt delivery of food to the patients.
- Staff had opportunities and were encouraged to continue their professional education.
- There were regular rolling shutdowns in theatre to allow for education and development to take place.
- There were excellent examples of multidisciplinary working in surgical teams.
- The surgical teams worked across 7 days, with consultant cover 7 days per week.

However:

- The trust's performance in patients having hip fracture surgery was not achieving the national standards in some areas, although recent local audits showed improvements were being made.
- Some senior staff we spoke with had not had Mental Capacity or Deprivation of Liberty Safeguards training.

## Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. The trust developed policies and guidelines in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example, the national early warning system (NEWS) assessed and responded to any negative change in a patients' condition. This was in line with NICE guidance CG50.
- Patients having surgery had regular temperature observations and recording as per NICE CG 65 management of peri-operative hypothermia, both in the anaesthetic room and within theatre. We observed staff using patient warming equipment appropriately.

- Nurse led preoperative assessment was informed by NICE guidelines and the trust pre-operative assessment policy. The team used these to help them interpret blood results and to help them assess patients risk for their planned surgery. Staff assessed patients for venous thromboembolism (VTE) risk and took steps to minimise the patient's risk of developing a thrombosis (blood clot) in line with the NICE guidelines.
- There were surgical enhanced recovery patient pathways in use within the trust; these included for example, colorectal, major and minor liver surgery, cystectomy and upper gastro intestinal surgery. Staff adhered to these evidence-based pathways, to ensure they gave most effective treatment. The pathways used standardised documents to make sure there was little variation in processes.
- There was a trust 'new procedure policy' for surgeons who wanted to develop alternative techniques; any proposals went through to the governance and quality group. In general, there were parameters for new procedures, which must be cost neutral with associated training identified the evidence base would be discussed and a decision made.
- There were divisional leads for research and development; there was continual contribution to NHS trials and research. The cardiology care group had a university and hospital combined post, which worked well, and there were proposals for similar posts in the vascular and neurological specialities.
- We saw staff education boards in theatres labelled 'clinical effectiveness and outcomes', which had posted results of recent clinical audits.
- There was a corporate audit plan, which included national audits, which the trust was submitting data to, for example, the National Emergency Laparotomy Audit (NELA), National Joint Registry (NJR), and the national bowel cancer audit (NBOCAP).
- There was a trust wide local audit plan, which detailed 42 local audits that were taking place; surgery was involved in over 50%.

## Pain relief

- The trust had an acute pain team, which was available to support the management of surgical patients' pain within core working hours. The team was located within the anaesthetic team in theatres and supported surgical wards. The acute pain teams' methods were based on

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the Core Standards for Pain Management (2015). All nurses had to undertake competencies in the use of pain relief and the theatre recovery staff rotated into the pain team to gain specific competencies.

- There were no protocols or pre prescribed templates for post-operative pain relief, anaesthetists prescribed these individually. Staff told us that the team were very prompt to review a patient's pain relief if it was not effective.
- The pre-operative assessment clinic advised patients on postoperative pain relief, with information leaflets to read at home prior to their admission. On the day of surgery, their anaesthetist discussed plans for pain relief with them, for example patient controlled analgesia (PCA). The anaesthetists routinely prescribed anti-emetics (anti sickness medicines) for patients having an anaesthetic to prevent any nausea and vomiting.
- Surgical staff assessed patients' pain levels using a nationally recognised pain scale when the patient's pulse and blood pressure was recorded. We saw that these assessments had been completed appropriately on the charts we looked at.
- The acute surgical unit (ASU) reported that there had previously been delays in transferring of patient's details into the electronic prescribing system, which meant a delay in a patient receiving pain relief. Recently an acute package for pain relief was centrally loaded on the electronic system to prevent delays.
- Day surgery staff did not look after patients who had an epidurals or patient controlled analgesia infusion. Staff told us that if the patient's pain required more than oral pain relief then they would return to recovery for administration of intravenous pain relief. Recovery team was said to be 'very good' at resolving patients pain before they were returned to the ward.
- We witnessed ward nurses discussing the effectiveness of pain relief for a patient prior to having a complex wound dressing.

## Nutrition and hydration

- The trust employed housekeepers who were mealtime coordinators, they wore identifiable tabards; they delivered and collected the ordered food to the

patients. They fed back to the nurses any patients not eating or drinking their meals, however, they did not complete any records of what was eaten or drunk as this was a nursing role.

- Nurses completed malnutrition universal screening tools (MUST) assessments on the patients' admission and actions taken when appropriate. For example, patients assessed as at risk had referrals to dietitians or speech and language therapy (SALT). We saw red trays in place when a patient was in need of some assistance with their food. Nutritional supplements were available when required.
- We examined food and fluid charts which were in use when a patients nutrition was being monitored, of the six seen, four were not completed. The majority of fluid balance charts were fully completed, although not always totalled and balanced every 24 hours. There was a nil by mouth protocol for starving patients prior to surgery.

## Patient outcomes

- The trust reviewed patient outcomes via the quality committee, and in the clinical outcomes work stream report.
- Between April 2015 and March 2016 the surgical patient spells (the stay of a patient using a hospital bed) were 36,907. These spells were 36.3% day cases, 28.2% elective or booked admissions and 35.5% emergency patients.
- The trust had been a previous 'outlier' in its performance as assessed by the CQC in the following cases. Patients with a hip fracture, in patients having acute renal failure, head injury and coronary atherosclerosis. The trust had investigated the patients' outcomes, actions had been taken and they were being removed from the CQC lists.
- The trusts outcomes summary showed that many of the audits were rated as 'green', this meant that the outcome data was as expected. These included colorectal cancer and urology surgical outcomes.
- There were some rated as 'red' or a negative outlier within the surgical specialties outcome performance, for example, patient reported outcome measures (PROMS) in knee replacements and in best practice performance in fractured hip patients.

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- In the review of national PROMS by the trust dated January 2017, there were plans outlined to investigate the knee replacement data. These included a notes review, targeted occupational therapy and an analysis of the commissioning patterns for any changes.
- The best practice national tariff compliance was important, as the components of the tariff give the best outcomes to patients with hip fractures. The trust data shows that the achievement of the tariff over the past year between December 2015 and December 2016 had varied between 60- 81%.
- In the 2016 hip fracture audit, the proportion of patients having surgery on the day of or day after admission was 72.8%, which does not meet the national standard of 85%. The 2015 figure was 73.7%. The teams had targeted improvements; however, they acknowledged their challenges of major trauma emergencies took priority. The trust had recently audited their 2016 performance and local figures showed that they were now meeting the national standard of 85%.The perioperative surgical assessment rate was 98.3%, which did not meet the national standard of 100%. The 2015 figure was 95.2% so the trust had improved.
- The proportion of patients with hip fractures documented as not developing pressure ulcers was 32.5%, which was in the worst 25% of trusts. This figure was extremely low in comparison to the National Aggregate for England and Wales (94.2%). We are aware that there may have been increased reporting of lower grades of pressure ulcers as the trust had been making efforts to improve pressure ulcer care. In the previous year, 2015, 97% of patients with hip fractures were documented as not having developed pressure ulcers. There were actions agreed to try to improve on the performance, which included an IT admitting protocol to enable accurate data collection.
- The trusts performance in national bowel cancer audit 2016 was within national expectations.
- The NELA risk-adjusted 30-day mortality rate for the trust in 2016 was within expected limits based on 240 cases. The trust achieved an amber (50-79%) rating for the proportion of cases with pre-operative documentation of risk of death. The trust achieved a green rating or above 70% of cases accessing theatre within clinically appropriate time frames and the highest-risk cases admitted to critical care post-operatively.
- Between March 2015 and February 2016, patients at Southampton General Hospital had a similar expected risk of readmission for non-elective admissions and a higher expected risk for elective admissions. The elective patients in the care groups of Urology and Ophthalmology had the highest relative risk of readmission.
- Within the vascular audits of carotid endarterectomy procedures, the timeline from symptom to surgery was 11 days, which was better than the national standard of 14 days.
- The national institute for cardiothoracic outcomes research (NICOR) data that showed the survival rates of patients following cardiac surgery between April 2012 and March 2015 was slightly better than what was predicted at 98.5%.
- The neurosurgery national audit programme report showed that the mortality rates for adult neurosurgery were within the expected range between April 2012 and March 2015.

## Competent staff

- The trust had an educational structure, with a senior lead for education in each division and a lead within in each care group. Staff training records were stored electronically in the 'virtual learning environment' (VLE). The education lead updated the records.
- There were regular rolling shutdowns of theatres for staff education and training; although CEPOD and trauma lists still ran, the education was multidisciplinary and included lectures and presentations. Theatre staff were often taught specific surgical techniques by consultants in theatre.
- Operating department practitioners (ODPs) felt that there were good opportunities for their development; their individual needs were reviewed every year at appraisal.
- Recovery staff told us that they had between three to six months to gain competencies for their roles, which included pain and airway management. They had access to courses and further competencies so that they would be able to take on an extended role and look after any patients held in recovery appropriately. Theatres mentored all new staff; there were regular 'one to ones' every one to three months and a yearly appraisal.

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- The trust target for appraisal completion was 92%, out of 41 surgical wards and departments, 36 had not achieved the target. The trust data we received showed that surgical wards and departments were on average 71% compliant.
- The medical staff compliance was on average 32.5%. Staff with appraisals due had a notification via the electronic staff record; the quality of the appraisal was assessed via the staff survey.
- Appraisals for Band 8c and above were against their job description, as evidence that they were leading and sharing the trust vision.
- All staff told us they were encouraged to access further education, following the achievement of their competencies. Surgical staff in Band 6 and 7 posts were expected to have 'master's level' degrees. Staff told us of the development of a bespoke surgical 'master's' course.
- The trust had delivered leadership development to surgical teams and senior medical staff, there had been a change of culture since and recently medical trainee feedback had improved.
- Mentors were in place in most wards, and for more experienced staff facing revalidation, study days were available.
- Some student nurses we spoke with told us that they felt well supported in the ward environment. Senior staff assigned them 'buddies' and mentors who coordinated their shifts so students were always supervised. 'Student pages' were available and accessed prior to their placements which made sure they were well prepared for the ward.
- There were various in-house courses, which were popular for staff; these included the neurosciences course, trauma and orthopaedics. Staff felt keen to advertise these as aids to recruitment, which was seen taking place.
- We saw that there were 'How to' folders in wards and departments, and staff could access master copies if required.
- Previously there was an ophthalmology course which was no longer available, so senior staff were looking to develop a local course to ensure essential specialist skills are learned by new staff.
- Most ward staff we spoke with were unaware if there was any formal supervision in place, although it was not highlighted as an issue. Some staff spoke of regular one to ones with their managers.

## Multidisciplinary working

- Most wards had multidisciplinary team (MDT) meetings early in the morning to discuss the patients' needs and plans via the white board, these included physiotherapy, nursing and junior medical staff. Ward teams described excellent MDT working and felt able to call the consultant on take if needed in emergency.
- We witnessed a surgical handover attended by surgeons, nurses, and managers. There was a discussion of the patient's diagnosis and treatment options, and theatre lists agreed.
- The handover in ASU was not fully multidisciplinary but attended by medical and administration staff, the consultant ward rounds followed the handover.
- The preoperative assessment unit was a nurse led process with daily support from the anaesthetist based in the unit. Each session was for a specialty so nurses knew when a specialist anaesthetist was in the department to ask for specific guidance.
- The outreach team were described as very approachable and quick to attend, they escalated any patient concerns to the appropriate medical team.
- Day surgery and theatres worked together as a team, the urology day surgical team had three consultant leads, and the cystoscopy lists had a consultant, registrar and two nurse practitioners.
- There was a one-stop fragility service, which had an ortho-geriatrician, clinical nurse specialists and orthopaedic surgeon. A head injury clinical nurse specialist coordinated the patients with head injuries across the trust.
- Theatre teams were observed to work well together for the safety of the patients.

## Seven-day services

- The care groups in surgical specialities worked in different teams but there was consultant cover in each, across the seven-day period. One of the divisional teams had taken the lead for seven day working in the vanguard project.
- ASU had a medical handover every day at 8-9 am, and daily consultant ward rounds took place seven days per week. Staff told us that consultant led ward rounds used to take place five days per week, but were now across

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seven days including weekends. A registrar was available for patient concerns, even if the consultant was in theatre. Staff told us it was sometimes more of a challenge to get support at weekends.

- Ophthalmology theatre lists took place six days a week, Saturday lists were mainly for private patients, and Sundays were for emergencies only. Anaesthetists came from central theatres if there was an emergency out of hours.
- There was seven day working in trauma and orthopaedics, with three theatre sessions per day taking place to support the workload. Consultants saw patients Monday to Friday in trauma and orthopaedics, with cover for a one in twelve long weekends Friday to Monday pm. There were 12 trauma only and 12 elective only consultants.
- Neurosurgery and cardiology covered consultant ward rounds at the weekends.
- Endoscopy slots were available seven days a week for both routine and emergency cases, multiple diagnostic and therapeutic interventions were undertaken. The service provided a 24 hour emergency on call provision which supported both local patients and other hospitals in the region..
- Physiotherapy was available in some care groups at the weekend, for example trauma. Imaging was fully seven days a week and pharmacy for six days with access on Sundays.

## Access to information

- The trust had experienced ongoing problems with the new IT system, which meant that data relating to mandatory training compliance was inaccurate.
- There had been a new electronic system live for the previous two months, for the recording and calculation of NEWS scores automatically, which meant that all patients could be viewed via an electronic tablet.
- We witnessed multidisciplinary handovers with good IT support, used to review patient scans, plans, blood results and x-rays.
- Pre-operative assessment nurses had access to an on line clinical decision making guide, which listed medical conditions, expected anaesthetic problems and indicated which pre-operative tests were required. The guide was changed as national guidance changed, for example, blood pressure guidance recently changed via NICE so the on line guidance changed.

- The trust produced nursing rosters electronically; which enabled senior staff to look at rosters in detail across their area of responsibility. Staff we spoke with told us that they could access rosters about six weeks in advance.

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

- We saw an education board in theatres relating to the MCA and Deprivation of Liberty Safeguards (DoLS), there were pointers to help staff in identifying vulnerable adults. Some senior ward staff we spoke with had not had MCA or DoLS training although they stated that they knew whom to contact.
- The pre-operative assessment team arranged a capacity assessment and best interests meeting prior to the patient's surgery taking place. The need for a capacity assessment had recently been added to the booking card needed for the patient to be added to the waiting list.
- We witnessed in depth conversations of complex patients regarding best interests meetings. Some staff were having educational sessions about the 'best interests' of patients with learning disabilities (LD).
- All surgeons came to see their patients prior to surgery, when they explained and obtained their consent; we witnessed this, which was very thorough with good explanation. In an emergency, surgeons acted in the best interests of patient and discussed with the family. For those patients who appeared to lack capacity for consent a separate consent form was used.
- We looked at completed consent forms in the 12 sets of patient records we reviewed, we saw that they were completed correctly and were signed and witnessed in the correct places with documented risks to surgery.
- Ophthalmology staff highlighted their concern over the consent process of some LD patients, they were aware that staff education was taking place.
- Allied health professionals understood the concepts of mental capacity assessments and had received training, however they had not had DoLS training and some were unsure of the process. There was no evidence of this impacting on patient care.

## Are surgery services caring?

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Good



We rated caring as good because:

- The trust ward level 'recommended' results were over 90% in the majority of Friends and Family test results.
- Staff, throughout our inspection were seen to be caring and passionate about giving good patient care. They were excellent patient advocates.
- Staff upheld patients' privacy and dignity whenever possible, despite some environmental constraints.
- There was timely and accessible psychiatric support for older people and for adults, which supported their recovery.
- There was enhanced care support for the wards to provide emotional support and guidance with patients with challenging behaviour.
- Patients confirmed their awareness of their treatment plans and that they had been discussed with them.

## Compassionate care

- The national Friends and Family Test response rate for surgery between February 2016 and January 2017 was 27%, which was slightly lower than the England average of 29%. Monthly ward level 'recommended' figures ranged from 0% to 100% with the majority of results being over 90%.
- The care groups governance reports discussed patient feedback and displayed the results on boards within the wards.
- On inspection, we saw staff were passionate about the care of their patients, ensuring that patients were comfortable and pain free. Staff we spoke with told us that staff shortages could affect their achievement of this, but they did their very best despite the shortages.
- Feedback from patients we spoke with was very positive and included comments 'staff wonderful', 'no complaints', 'treated with respect and sympathy', 'buzzers left in easy reach'. 'Staff are awesome', 'brilliant from start to finish', 'lots of details about procedure', 'totally and utterly understood my procedure', 'star of the day was the anaesthetist', 'doctors are fantastic'. 'Overall the care is excellent', 'cannot praise staff highly enough', 'when I call, staff they come when they can'.

- We saw notices on wards explaining how ward staff were trying to maintain patients' privacy and dignity. There were thank you letters, staff photo boards and staff on duty.
- Some wards observed rest times for their patients, and between 1.30pm and 3pm lights were dimmed.
- Most wards displayed visiting times with a 'visiting code' involving meal times. However, in some areas there were no signs indicating visiting hours, we saw some visitors were unsure of these.
- We witnessed the thoughtfulness of staff ensuring patients had any hearing aids put back in as soon as possible so they could hear staff speaking to them after their surgery.
- One patient commented that 'night time responses to patient buzzers could take a long time'.

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

- We listened and witnessed ward handovers when it was obvious that the staff knew their patients well and could advocate for them if need be.
- The staff name badges all show 'Hello, my name is ...'. Wards and departments had photo boards and uniform explanations to help patients identify staff.
- Patient and visitor boards displayed information relating to the wards philosophy, ward information, how to raise concerns, numerous information leaflets and privacy and dignity explanations.
- Patients we spoke with confirmed that staff gave good explanations of any care interventions, and checked that there was good understanding.
- We saw that patients, who were able and wanted to, were able to walk to theatre. When they walked to theatre from the day of surgery admissions, they left the unit via a separate exit to maintain their privacy and dignity. We saw patients wearing slippers and dressing gowns walking to theatre.
- Ophthalmology patients were given full instructions and a help number to call for any worries before they went home, staff would bring patients back to the unit for review if they were concerned.
- Patients were asked about their home support when they were admitted, relatives were engaged wherever possible in planning for their discharge.
- Patients we spoke with were aware of the plans for their care and confirmed that this had been discussed with them.

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## Emotional support

- Patients were given specific information leaflets relating to their forthcoming surgery at pre-operative assessment to prepare them and alleviate any concerns prior to admission.
- Patients and families were supported by numerous nurse specialists who followed the patients care pathway, and as a specialist resource for particular concerns. For example, thoracic, urology, colorectal specialist nurses were able to offer practical and emotional support to the patients having surgery.
- We witnessed the sympathetic and patient explanations to a deaf patient having surgery.
- Psychiatric support was readily available; there were both mental health and elderly mental health teams. Wards called the on call team for help and the site manager to assist if needed. We saw that patient referrals had been made to the mental health team and patients were seen the following day. Staff told us that psychiatric input was available for discharged patients and could be pre-arranged for community visits after the discharge date was known.
- There was an 'enhanced care support' team to support patients with challenging behaviour, such as those patients living with dementia or a learning difficulty. The team would visit the patient and relatives, to assess the patient and then suggest care plans and coping strategies for the patient's particular issues to the ward teams.
- Most ward areas did not have any quiet room facilities for relatives to use or for giving bad news. However, the trust had created a shared directory so all wards would have access to a room.
- To support them, inpatients had regular access to spiritual support every Sunday via an onsite team, wards were aware of their contact details and displayed details on the patient information boards. Ward staff could also contact the named link chaplain for their clinical area, who took a particular responsibility for visiting and working with patients in their areas.
- There were specific faith contacts available for patients to access; however, ward staff could make an urgent request for a visit to the switchboard. A member of the hospital team would attend to a patient or relative, whatever faith the patient was, if this was requested. There were some quiet prayer facilities for different faiths in the hospital.

- Patients or relatives could access bereavement counselling if it was required, ward staff were able to contact the bereavement care team on their behalf. There were specific bereavement care leaflets available on the wards and via the hospital website.

## Are surgery services responsive?

Good



We rated responsive as good because:

- The trusts performance in referral to treatment times was better than the England average, although it still did not meet the national measure.
- Patients attending day surgery were given pagers so they did not have to wait in a crowded waiting room.
- Recovery were able to discharge low risk patients direct from the recovery area, to maintain better patient flow.
- The day surgery displayed flexibility in opening times, patient case mix and supporting the trusts flow.
- There was a new surgical discharge lounge in operation.
- Although most ward areas did not have any quiet room facilities for relatives to use or for giving bad news. The trust had created a shared directory so staff could access a room when required.
- Teams regularly reviewed surgical outliers daily.
- There was good access to interpreters through either trained staff or an external company.
- We saw patients living with dementia or with learning disabilities had their individual needs assessed and met. The trust had taken part in the 'Tools to Care' initiative and was now an 'exemplar site'.
- There was excellent mental health support for patients who needed it.

However:

- Patient flow was challenged throughout surgery. The trust had moved some patients frequently for reasons of clinical care, to create capacity and prevent patient waits; some patients told us they had been moved up to four times.
- Hip fracture patients stayed four days longer in the trust than the national average, although the trust reported this data took into account their rehabilitation ward and healthcare at home and therefore the information was not an accurate reflection of the trust performance.

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- There were few patients' facilities that were gender specific as per Department of Health guidance.
- Some single sex breaches had taken place in the acute surgical unit.
- There were some negative comments from patients relating to the quality of meals. Staff told us there were sometimes insufficient meal delivery trolleys to deliver hot meals.

## Service planning and delivery to meet the needs of local people

- The surgical senior teams told us that they were working with neighbouring trusts to support various activities, for example vascular and spinal surgery.
- They provided high acuity elective surgery as the 'majority' of low risks cases were going to the local independent organisation under a NHS commissioning contract. The teams felt there was a particular challenge with a lack of elective critical care capacity needed for the high acuity patients, which caused patient cancellations.
- Theatres were regularly putting on extra lists to support waiting list initiatives (these were specific extra lists to support the reduction of patients waiting times and to achieve government access targets). There was an additional seven to eight WLI lists put on every week.
- Theatres planned to work regular seven days a week with lists every day. Saturday WLI lists were regularly set up for up to ten patients to ensure that patients with cancer did not wait longer than the recommended two weeks.
- Normal practice was to run two CEPOD emergency lists at the weekends, opening up a second theatre during the week if there was no capacity in any other theatre and it was required for emergency patients. These would be staffed by 'cross covering' between the cardiothoracic and neurosurgical teams.
- The ophthalmology theatre staff only worked within ophthalmology. Their lists ran until 8pm, with some Saturday lists and an on call service. Sundays were for emergencies only. Preoperative assessment for patients having a general anaesthetic was in the trust main department. The ward staff carried out pre-operative assessments for local anaesthetic or for cataract surgery.
- There were some variations in the number of cases per ophthalmology list depending on the consultant and his instructions. Staff we spoke with told us the capacity in ophthalmology theatres was becoming insufficient. Future developments were agreed in principle, and the divisional team were exploring various locations.
- The ophthalmology department was located away from the rest of theatres; however, there were usually an anaesthetist present in the theatres, which were adjacent to wards. Staff used the emergency buzzers and called the team by the phone using the 2222 system for assistance.
- Private patients were operated on within the theatre complex. Theatre staff told us there was no difference to their care in theatres. There were usually on 'private patient' weekend lists so they did not impact on NHS lists and staff got paid enhanced bank rates.
- The teams had seen an increase in cancer referrals to head and neck services due to the increasing public awareness of cancer. Whilst this was positive, it had created a heightened demand which the teams were working to respond to.
- Most areas in the trust did not have gender specific toilets and bathrooms, they used sliding male – female signs to illustrate the facilities could be used by either gender. This meant that patients in dressing gowns might have to walk past a number of patient bays before accessing a vacant toilet or bathroom. The trust facilities should be assigned as gender specific ensure compliance with the Department of Health guidance on patient facilities.

## Access and flow

- The trust's referral to treatment time (RTT) for admitted pathways for Surgery has been better than the England overall performance since November 2015. The latest figures for October 2016 showed 75% of this group of patients had treatment within 18 weeks versus the England average of 71.4%. However, both the trust performance and the England average were well below the 90% measure.
- The trust had met the national standard of 92% compliance for patients waiting to start treatment excepting December 2016 and January 2017.
- Between April 2015 and March 2016, the average length of stay for surgical elective patients at Southampton General Hospital was four days, compared to the

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England average of three days. For surgical non-elective or emergency patients, the average length of stay was seven days, compared to the England average of five days.

- The best care group for RTT performance was cardiothoracic surgery that had achieved 91.6% of patients treated within 18 weeks, the England average was 85.5%. The worst performance was oral surgery, which achieved a performance of 58.8%, the England average was 71.8%.
- Due to emergency cases taking priority, planned operation cancellations sometimes took place. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient had not had treatment within 28 days of a last-minute cancellation then this was recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. One patient told us he had been cancelled twice and was unsure of when he would eventually go to theatre.
- The trust held a daily bed meeting at 8.30 am to ensure that all patients planned to have surgery would have a bed. There was a further review at 11.30 am when there was a discussion regarding the location of beds and whether post-operative patients needed to be held for longer in recovery. Cancelled operations were generally about a lack of bed capacity especially high dependency beds. Staff told us that lists would overrun rather than cancel patients, which happened frequently.
- The trust had performed significantly better than the England average for rescheduling cancelled operations, the latest national figure for cancelled patients not being treated within 28 days was 7.3%. The trust was lower at 5.5%.
- Cancelled operations as a percentage of elective admissions for the period December 2014 to September 2016 at the trust were greater than the England average. The trend was improving and in the latest quarter was 1%, which was very similar to the England average of 0.9%.
- The surgical booking office teams managed cancelled patients and tried to rebook the patient's admission to take place within 28 days. Staff aimed to give the patient their new date of surgery before they left. If there were cancellations, the space was backfilled with other DSU patients and CEPOD or emergency work used the theatre space.
- The trust monitored and audited prolonged stays in recovery; recovery staff were able to give patients food and drink and had developed a system to discharge patients straight from recovery to improve flow. This was for minor surgical patients and prevented inpatient beds being used by minor operations in day surgery unit (DSU). Nurse led discharge protocols were in place.
- The trust used DSU for both day cases, and as a surgical admissions unit since it was opened in 2012. There was no dedicated theatre, as patients went to specialty specific theatres throughout the trust. The trust used DSU mainly for cardiothoracic, interventional radiology, orthopaedics and general surgical patients.
- The DSU had six additional beds for 23 hour stays, which could increase up to 18 beds as a response to winter pressures. The patients admitted here were simple post-operative cases, for example if there was no home support for a post-operative patient. Sometimes inappropriate patient moves occurred, the bed managers were alerted, and the patient was moved to a more appropriate bed. There were no medical outliers, the arrangement was to take patients from surgical wards who needed up to 23 hours care, to free up beds for medical outliers. Sometimes, the unit had to open up to 18 beds for overnight stays, it was supposed to close on Saturday nights but due to bed pressures, this did not always happen.
- The trust provide data which showed that 565 patients or 9% of day cases converted to overnight stays due to incorrect listing as a day case, or later than planned finishing of the procedures.
- The numbers of patients staying in the DSU affected the space available for DSU patients. If a patient needed to be cancelled, it was done by the operational manager, or nurse in charge.
- Theatre utilisation from January 2016 until December 2016 was highest in the thoracic surgical team who routinely used between 85% and 93% of their theatre capacity. The lowest use was in Neuro 1 where they used between 52% and 68% of the capacity available. The trust told us that the neuro theatre operates at a lower capacity in order to maintain emergency flow as per national best practice (NHS England commissioning policy 2013)

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- The acute surgery unit (ASU) suffered from a lack of flow if there were no ward beds to take patients, if this happened then the bed managers helped to speed up the discharges.
  - We witnessed a backup of patients in theatre when the recovery was full; theatre staff were asked to 'hold patients' until there was space for them in recovery. Staff we spoke with said this happened quite often, and held up lists, which meant there might be an overrun at the end. This issue had been raised to the senior teams and was on their risk register.
  - A new surgical discharge lounge had opened within the last eight months, which housed six surgical patients. Patients awaiting transport, medicines to take home, or discharge information would be moved here to free up their beds and await collection or their transport.
  - The urology 'day unit' was three rooms located in the day surgery unit used for up to 18 patients per day. The trust used the facility to provide a large range of urological services for example chemotherapy, trial without catheters, urodynamic and lithotripsy. The staff felt the service was overwhelmed with waiting lists and capacity issues. There were also satellite clinics and lists held in other locations. The workload pressure had been managed by a mixture of extended or three session days and weekend working.
  - Staff highlighted and we saw that within the urology day unit there was no private room available for difficult discussions relating to cancers or personal issues. However, the trust told us there were private rooms elsewhere within the main outpatient department.
  - Complex surgery cases, such as the 'Whipples' procedure for pancreatic cancer, were admitted the day before to ensure that the patient was fully prepped. There was an enhanced recovery pathway for elective orthopaedic patients, which included joint school to ensure patients were prepared for their discharge after surgery.
  - We saw an in depth discussion of non-surgical patients such as medical who had been moved to empty beds (known as outliers) and other specialty patients' plans of care discussed at the daily acute surgical handover, led by senior doctors. The consultant reviewed the patients the following morning. Results were followed up of radiological investigations and discharge plans agreed. Some patients were booked for outpatient investigations rather than as in patients, to keep the beds available for emergencies.
  - Any orthopaedic patients out lied to a non-orthopaedic ward would have a daily review by an advanced nurse practitioner to ensure that orthopaedic specific nursing and clinical care was being given. These were usually long term or low risk patients for example, non-union of fractures or partial weight bearing cases.
  - Some consultants reviewed and managed patients at home to help with flow. They did extra afternoon ward rounds to help with clinical decision making to improve patient flow when requested.
  - There was a 'UHS at home' service provided by an independent organisation to provide a responsive maximum two week care package which was to enable earlier discharges. They were able to provide 'bridging' for patients awaiting care packages provided there was a date for care to start.
  - There was access to rehabilitation wards or support for patients at home and there were some non-weight bearing beds in Hampshire for orthopaedic patients who needed a longer recovery pathway. We saw patients with their discharge planned and transport was booked.
  - The trust had moved some patients frequently for reasons of clinical care, to create capacity, and prevent patient waits; some patients told us they had moved wards up to four times.
  - The trust admitted 591 patients with hip fractures in 2016. The patients stayed on average four days longer at 24.8 days than the average length of stay in England and Wales, which was 20.7 days. However, the trust stated the data inputted was incorrect and included data relating to patients having rehabilitation in hospital and at home.
  - We were told that there were significant issues with patients needing care transfers, these could be as a result of funding panels, continuing healthcare assessments or a lack of available agencies to provide care.
  - Patients said that the 'car parking could be awful' and it affected their experience negatively.
- ### Meeting people's individual needs
- The DSU adhered to single sex zones, which had single toilets per zone, the single rooms all had ensuite facilities. ASU told us that single sex breaches

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sometimes occurred to maintain patient flow, the single rooms were used first, and then the patient's permission requested, the site manager was informed. This was against Department of Health guidance.

- The concerns regarding mixed sex breaches was identified in a trust board report in 2016, where it was reported from a patient experience perspective that almost 30% felt they had been cared for in a mixed sex environment. However, further breaches were found on the inspection, not always identified or declared by the trust, and not monitored.
- The surgical preoperative assessment process included capacity questions relating to dementia. If the patient was living with dementia, their relatives or carers were encouraged to stay with the patient whenever possible. The information was shared, if the preoperative assessment team were already aware of the dementia prior to the appointment, a double slot would be booked to allow more time.
- Patients with learning disabilities (LD) who were booked or elective admissions were also flagged at preoperative assessment, the LD team liaised with the patients at home or at school to find out their background and if they had a 'patient passport'. The team carried out the patient's capacity assessment and best interests meeting before the patient was admitted. Theatres were notified in advance. The theatre team told us that the anaesthetist highlighted patients with learning disabilities at the team brief stage of the safety checklist. A side room was made available if possible, and carers were encouraged to accompany the patient into the anaesthetic room in theatre and meet them in recovery. The team tried to ensure these patients had as short a stay as possible in hospital.
- Although the LD team was small, staff shared with us that they were supportive and helpful. The team were well known throughout the trust, the referral process was in the resources list within 'how to' folder and available via switchboard.
- Preoperative assessment recognised the need for an interpreter of elective or booked patients and ordered one for the patient's admission. The trust had some staff with a second or third language, which had attended an interpreter course and were available to assist in emergencies.
- Interpreters were alerted of the need for surgical consent so they were available when needed, contact details were held in the 'How To' folders. Out of hours, there was telephone access to an external company: they were usually able to respond quickly. Staff we spoke with were aware of the trust policy, which was 'always followed', and relatives were never used.
- Some wards had posters of how to obtain leaflets in other languages. Information leaflets were freely available; each one had a contact number on the back for requesting the resource in a different language.
- Patients who had complex medical histories had an anaesthetic review and assessments prior to surgery, some needed cardiopulmonary assessment and were referred for specific testing. These were normally those patients being prepared for cardiothoracic surgery.
- Dementia training was available for link staff, although there were no mental health liaison nurses based within the trust. Staff told us that two wards had taken part in the 'Tools to Care' initiative and were now trust exemplar sites.
- The mental health provision for surgical patients was available Monday to Friday from 9am to 5pm, the provision for the acute medical unit was across seven days, the same times. The emergency department (ED) was supported for 24 hrs, seven days per week. The teams comprised of older persons mental health, adult mental health, psychology, and substance misuse. In addition, there was specific support to the enhanced care team, and to the vulnerable adult support team.
- Most ward areas did not have any quiet room facilities for relatives to use or for giving bad news. The trust had created a shared directory was so that all wards would have access to a room.
- In day surgery patient pagers were given to patients waiting for their surgery, allowing patients and relatives to leave the department. This prevents overcrowding and enables staff to call patients back when they are needed.
- In general, there was mixed patients feedback to us about the standard of food. Positive comments included 'food was ok considering how many to cook for', 'good choice and sufficient.' Negative comments were, 'sometimes food was cold.' 'staff always start one end of ward so cold by time it reaches me at the other end' 'not wonderful' . A patient commented that their high protein soft diet 'was not good, protein portions were very small' other patients commented that food was

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'inedible' on more than one occasion. We saw some patient feedback on one ward information board that, 'staff were not aware of food allergies and wrong food was given'. There were no actions displayed.

- Staff we spoke with told us that day surgery patients were able to access hot meals, as some stayed in for longer than 12 hours. Sandwiches, snacks and drinks were available throughout the day for day surgery patients. ASU provided meals when patients missed their lunch due to investigations away from the ward. The ophthalmology unit provided tea and toast to patients following their procedures.
- Staff told us that they were concerned that more meal delivery trolleys were needed as some were 'shared', causing a delay in the delivery of hot food.

## Learning from complaints and concerns

- Between July 2015 and June 2016 there were 68 complaints about the 'surgical care groups' clinical treatment at the trust.
- The trust staff gave some examples of recent complaints, issues relating to pain relief, delays in being seen by doctors, and problems with food. Staff fed back to us that the housekeepers had improved some of the food issues, specifically regarding feeding patients and getting hot food. All complaints were talked about in ward meetings and in clinical governance meetings, so learning and any changes in practice were shared.
- Feedback from patients in the DSU led to the adoption of patient pagers to enable patients who were waiting for surgery to be able to go for a walk and be alerted when they needed to return.
- Pre-operative assessment gave an example of updating patient's information relating to stopping anticoagulant medicines, as this issue had caused cancellations on the day of surgery in the past.
- Discharge complaints specifically about waiting for medications had resulted in the 'home by lunch project'. Following another, when there was a delay in medicines being dispensed at the weekend, the pharmacy hours had been extended from 9am through to 4pm.
- The cardiac service provided a follow up call post discharge to patients; this was put in place after complaints from patients that they were discharged too soon with no rehabilitation. Rehabilitation was now pre-arranged with the patient before they left hospital.
- ASU had a 'you said we did' board which displayed feedback for example, food, the times of senior doctor

visits and the plans for the new waiting room. There were posters displayed in different languages, which were also available in large print or braille and audiotape. There were information leaflets about ASU. We saw leaflets about how patients could make a complaint or comment.

## Are surgery services well-led?

Good



We rated well-led as good because:

- Surgical teams had strategies for development and improvements that linked into neighbouring trusts.
- A good governance structure fed into the central trust governance meetings.
- Local risk registers were in place and were clearly updated and maintained and staff were aware of their highest risks.
- Regular morbidity and mortality meetings reviewed care processes and unexpected deaths for learning points.
- There was clear, accessible and visible strong trust leadership.

However:

- The governance process in place did not identify a number of risks identified during this inspection. These included concerns about mixed sex breaches on the ASU, surgical theatre equipment availability due to repair times and safety testing, and availability of air mattresses.

## Leadership of service

- Teams of three seniors led the trust divisional teams, which were involved in delivering surgery. A divisional clinical director (doctor), a divisional head of nursing/professions (nurse or allied health professional) and a divisional operational manager.
- Staff in the ASU stated that their leader's skills were excellent, and their senior managers were visible and cared about the members of staff.
- Staff we spoke with told us of the CEO forums and blog, they looked forward to reading it.

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- The trust had a new 'talent management' project which staff had to apply for, ten staff had been recently accepted. The scheme was to look at their skill sets, to help them in their development and included 360° feedback.
- There were regular informal walkabouts by matrons across care groups, which took place at least once a week. Feedback was provided immediately to wards with the wards own matron following up.
- The theatre manager also walked around, staff felt them to be accessible and fully aware of operational problems.
- Most ward leaders expressed their pride in their ward teams and the care they provided to patients. Their ward or department meetings happened regularly; notes taken and shared with those staff unable to attend.
- The staff described the executive team as visible and approachable, with regular planned and unplanned walkabouts taking place. The non-executive directors also visited with the chairman and board members, both in and out of hours.
- The trust values were 'Working together, Putting patients first, and Always improving' some key statements underpinned these in a 'constant drive to improve quality safety and efficiency'.
- There were eight top priorities for improvements, which were the guiding principle framework for any developments to link to. The vision and strategy with the detailed priorities was available for staff and for patients and relatives via the trust website.

## Governance, risk management and quality measurement

### Vision and strategy for this service

- The trust had a clear vision to 'Work with our partners at the leading edge of health care for the benefit of patients'. The trust stated their mission was as 'To be better every day'.
- We spoke with the senior teams for the surgical services. They described their strategic direction as linking with the trusts' in providing regional surgical services. Each division had an individual strategic plan with priorities for development and growth detailed.
- There had been recent work within the areas strategic transformational plans to improve working with neighbouring trusts across the south of England.
- The team described the challenges in the repatriation of patients to other trusts had become increasingly difficult following becoming a trauma centre.
- They described developing a strategy to improve the RTT performance position, and to improve theatres efficiency.
- There was also a strategic nursing plan, which detailed the workforce priorities and the impact of the nursing workforce on other priorities for the coming year.
- The trust divisional teams attended the trust quality and governance steering group, which was chaired by one of the executive team. Divisional teams held their own monthly meetings with the care groups or specialities in their divisions. They reviewed all clinical incidents every three months, to identify any themes. The monthly care group or speciality governance meetings informed the divisional agendas.
- Senior leaders looked at performance dashboards and compared wards performance, which was discussed at the clinical governance performance meetings. All ward and department managers produced a monthly exception report, which they verbally presented every other month. Top divisional risks were communicated to them for sharing with their teams.
- All care groups had local risk registers; that combined into the divisional risk registers; risk coordinators managed these, and ensured that all risks had been assessed accurately before they were added to the register. Senior staff we spoke with could access their risk registers, and were aware of their highest risks and shared them with us.
- One example of actions following a risk being escalated, was a shortage of theatre trolleys which impacted on theatre lists. 48 hours after the risk being raised the theatre senior team obtained ten additional trolleys to alleviate the risk. However, there were some older risks such as the inability to achieve RTT compliance in ENT, which was still unresolved and regularly updated.
- The trust staff told us that DSU capacity and theatre recovery being constantly full were escalated to the divisional risk register. We saw the divisional risk registers and identified the high risks discussed by ward staff were present on the registers with mitigations and

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actions in place, most risks had been updated during our inspection. For example, we saw that staffing had been raised to the risk register of all the divisions involved in surgery, and was regularly updated.

- However the governance process in place did not identify a number of issues identified during this inspection. These included concerns about mixed sex breaches on the ASU, low appraisal rates within medical staff, surgical theatre equipment availability, and availability of air mattresses.
- The VLE system for recording staff training compliance was unreliable with some records not updating accurately. This meant that the compliance data was said to be inaccurate and managers could not be assured of their staff's compliance.
- The trust held a quality committee chaired by the medical director where patient outcomes were monitored. These included for example, national outcome measures such as PROMS, which the trust board required more detail on the performance.
- Monthly dashboards for care groups displayed performance results and monitored quality by using specific evidence in each care group. For example, care groups grouped performance within patient safety, patient experience, infection prevention, discharges and cleanliness. Results of the previous month's performance would be compared to their recent performance so it could be monitored.

## Culture within the service

- The divisional team leaders felt comfortable to raise issues with the executive team. They attended a weekly meeting with the chief executive officer and a fortnightly meeting with the chief operating officer. Patient safety was the underlying priority; the trust allocated resources to improve patient safety.
- The senior teams felt there was an open and fair culture within their teams. They told us there had previously been issues with a perception of bullying within some areas but these had been resolved in a remedial and safe manner.
- Trust staff reported that the change to a more visible approach in executive leadership was appreciated. They were aware that they could always speak to the senior team who were very approachable. They felt that 'patients always came first'.

- The trust culture 'was shifting to be more open and transparent'; clinical governance and ward meetings were used to openly share and discuss issues. We witnessed handover meetings where all staff were comfortable to speak up.
- Theatres had held 'speak up sessions' to encourage staff to have their say; these were aimed at band 2 s and above.
- There was evidence in one care group of a potential patient safety issue being raised over six months ago, which had not yet been resolved by the senior team, although we saw investigations had taken place. There were concerns raised relating to poor patient outcomes.
- Some ward staff felt that some patient facilities were not sufficient, they told us there was a shortage of office space, insufficient staff toilets and no showers to encourage cycling to work. They were not sure how to get these issues addressed.

## Public engagement

- The chief executive held patient lunches, staff and patients regarded these as unique and most welcome. Teams received feedback on any issues raised.
- There were focus groups within specific cancers for patient involvement although no patients took part in the governance groups yet. The trust used representatives from the local 'health watch' when planning major redevelopments.
- Ward patient information boards varied between wards but we saw that the majority had useful information displayed for example, car parking tariffs, domestic cleaning schedules, interpreters, staff uniforms and chaplaincy information.
- Patients in a ward area being upgraded had not been informed of the work being undertaken, there was no information available to explain what the 'drilling' noise was. We raised this at the time and the trust very promptly issued letters to the patients on the wards affected.
- Some wards and departments had public 'How are we doing' notice boards to illustrate numbers of patient falls, nutritional audits, medicine errors and pressure ulcers.

## Staff engagement

- There was a surgical newsletter every three months for updates and shared learning.

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- Nursing forums took place once a month in surgery, all grades of staff could attend. Matrons identified who will attend, however due to staffing issues in November and December 2016; these forums were cancelled.
  - A communication meeting took place regularly every Thursday to discuss staffing plans for the weekend.
  - Staff reported that the retention of staff was difficult, they wanted to be engaged in developing formal rotation programmes to try and prevent the overseas nurses leaving to gain further experience.
  - The ward sisters spoke of working towards accreditation and their pride in having 'exemplar' status.
  - Staff told us 'I really like working here, I have been here 20 years and have good support, the patient care is fabulous'.
  - Staff in the urology day unit told us they had been involved in the business case for a bigger unit with cystoscopy suites, plus a private room for confidentiality.
- Innovation, improvement and sustainability**
- Surgical services were setting up a scheme for nurses to do discharge letters for specific procedures using a set agreed template, to speed up discharges.
  - Ophthalmology theatre staff were about to set up injection clinics within the community.
  - Staff told us that innovation was encouraged in the trust, as 'one size does not fit all'. Ideas were trialled and successful ones shared across divisions. There was a very accessible improvement team to support new ideas and developments.
  - There had been a sustained reduction in hospital acquired pressure ulcers through the local pressure risk evaluation and skin screening tool (PRESS) initiative.
  - The trust had developed a staff recruitment video, which was on the trust website.
  - Staff had participated in the training to be an interpreter to reduce costs and waiting times for theatres.
  - Patients attending DSU were given pagers to allow them to wander; they would be paged when it was their time to get ready for theatre.
  - The theatre teams had designed a new surgical checklist as a response to the National Safety Standards for Invasive Procedures (NATSIPs) programme.
  - The new VLE IT system for recording training had proven unreliable in the analysis, staff had created lengthy workarounds to try and fill the gap, they were frustrated by the delay in getting it rectified.

# Critical care

|                |                    |   |
|----------------|--------------------|---|
| Safe           | Good               |  |
| Effective      | Good               |  |
| Caring         | Outstanding        |  |
| Responsive     | Good               |  |
| Well-led       | Outstanding        |  |
| <b>Overall</b> | <b>Outstanding</b> |  |

## Information about the service

There are 88 adult critical care beds in Southampton General Hospital. The general intensive care unit (GICU) has 25 beds and provides general intensive care treatment for elective, trauma and emergency patients. The cardiac intensive care unit (CICU), a regional centre for cardiac intensive care, has 14 beds and provides intensive care treatment for patients with cardiac problems, predominantly those undergoing cardiac surgery. The neuro intensive care unit (Neuro ICU) has 13 beds and provides treatment for patients with neurological conditions. This unit is a regional centre for neuro intensive care and provides treatment for a large number of patients suffering from an acquired brain injury. Within the constraints of staffing numbers, all the intensive care units work flexibly using beds to accommodate a mixture of patients requiring level 2 or level 3 care.

Level 2 beds are for patients who need higher levels of care and more detailed observation and/or intervention. These patients may have a single failing organ system or require postoperative care. Level 3 beds are for patients who need advanced respiratory support, or basic respiratory support together with the further support of at least two organ systems. Level 3 includes complex patients needing support for multi-organ failure.

The surgical high dependency unit (SHDU) has eight level 2 beds and treats patients who have had complex surgery and patients discharged from GICU. The respiratory high dependency unit (RH DU) has 9 level 2 beds and treats patients with acute or chronic respiratory failure. This can include weaning patients with tracheostomies from

ventilators and supporting discharge for patients using long term non invasive ventilation. The cardiac high dependency unit (CHDU) had a total of 19 beds. CHDU treated patients undergoing cardiac surgery and with cardiology conditions. The unit provides a Monday to Friday 'fast track' service, in which cardiac surgical patients are admitted directly from theatres and ventilated for a short period of four to six hours post operatively.

A 24 hour outreach service is provided by the critical care service. This service provides a specialist nursing team to give advanced clinical advice or treatment if a patient's condition deteriorates in the general areas of the hospital. Their aim is to prevent patients' conditions deteriorating to such an extent they need admitting to critical care beds.

The management structure of the hospital is divided into four divisions. The GICU, CICU, Neuro ICU, SHDU and the outreach service are managed under Division A. The RH DU is managed under Division B and CHDU is managed under Division D. Despite the services being managed by different divisions, there is oversight and associated leadership of the critical care services, ensuring they work together as a critical care team.

During the inspection, we visited all critical care areas. We spoke with 13 patients, 10 relatives and 52 members of staff. These included nursing staff, student nurses, junior and senior doctors, physiotherapists, pharmacists, housekeeping staff, technicians and managers. We observed care and looked at 22 care records. Before and after the inspection we reviewed performance information from and about the hospital.

# Critical care

## Summary of findings

We rated this service as outstanding because:

- Staff followed processes that promoted effective investigation into and learning from incidents.
- Risks associated with the environment were mitigated and plans were being progressed to make improvements to the environment and increase the critical care capacity.
- There was a highly effective education programme, managed by a dedicated nurse education team, for nursing staff working at all grades. The delivery of the education programme mitigated risk to patients associated with the service not meeting the recommended 50% of all qualified nurses having a post registration qualification in critical care nursing.
- Over all medical staffing numbers met the recommended national guidelines. In Neuro ICU, where this was not met, processes were followed to lessen the risk to patients due to there not being an intensivist on the unit at night.
- A comprehensive training programme of medical staff, supported recruitment and retention.
- An established critical care outreach team, available 24 hours a day, supported the early detection and effective treatment of patients whose conditions were deteriorating in the hospital.
- Delivery of treatment and care followed national evidence based guidance, and adherence to the guidance was monitored by a rolling audit programme. Data from national and local audits showed the critical care service delivered good outcomes for patients.
- There was effective multidisciplinary working in all critical care areas.
- Staff treated and cared for patients and their families with compassion and sensitivity. Patients and their families were involved in decision making processes about their care and treatment. All critical care areas provided a follow up service for patients after discharge.
- There was a supportive and effective leadership of the individual units and across all the critical care services.

- Governance processes focused on risk and quality of the service. The critical care leadership team felt supported by the trust leadership team in the management of risks and quality of the service.

However:

- Records management did not always protect the confidentiality of patients.
- There was a lack of detail about the patients past medical history and treatment during their current admission on discharge summaries.
- Fridge temperatures in some areas were recorded as being outside the recommended range.
- There was no dedicated critical care pharmacist available for support and guidance at weekends.
- In line with similar critical care services, bed occupancy was above the recommended rate of 70%
- The environment of some of the critical care areas posed challenges with meeting the individual needs of patients and their families. Mixed sex breaches for level 1 patients who were discharged from critical care were not monitored.

# Critical care

## Are critical care services safe?

Good



We rated safe as good because:

- Processes and procedures were followed to report incidents and monitor risks. Learning from incidents was shared across the critical care units.
- Infection control practices were followed. There were low numbers of unit acquired infections.
- Although there were risks to patients and staff associated with the environment for some of the critical care areas, action was taken to mitigate the risks and there were plans to develop and improve the environment.
- Standardised equipment across all critical care service supported safe care and treatment of patients.
- Staff followed processes to ensure electronic records were secure and confidential. Back-up systems ensured monitoring continued and records were not lost in the event of power failure.
- There was safe nurse staffing was safe across all the critical care units. There were appropriate numbers of relevantly trained medical staff to provide care and treatment safely.
- All the critical care nurses had completed specific training to give them extended scopes of practice.

However:

- The trust did not fully ensure patient confidentiality. Paper records were not always stored securely. In the surgical high dependency unit (SHDU), a theatre list with patient's details was displayed in an area visible to unauthorised personal.
- Medicine fridge temperatures in two areas were recorded as being outside the recommended range. This meant there was no assurance that medicines stored in these fridges were fully effective.
- Mandatory training rates for all staff groups were below the trust's 85% target for some subjects.
- Fill rates for nursing staff were lower than expected some months. When short the units utilised critical care band 4 support workers to care for patients overseen by qualified nurses.

## Incidents

- All staff in the critical care services who we spoke with knew how to escalate and report incidents.
- Staff reported incidents using an electronic reporting system. Guidance about using the system was provided in training and staff had access to guidance on the trust's intranet.
- The service used various ways to ensure staff received feedback about incidents. This included information given at handover periods, team meetings and by emails. Staff confirmed they received feedback about incidents they reported and where required learning from the incidents was shared across the units.
- We viewed a sample of RCA investigation records. These showed thorough investigations were carried out to identify the possible cause of the incident and identified learning and changes in practices to reduce the likelihood of similar occurrences happening.
- Mortality and Morbidity meetings were embedded into the running of the units. The records of mortality and morbidity meetings showed the treatment and care practices for the patients were critically reviewed, and where appropriate, proposed changes of practices identified. When appropriate learning was shared with other departments within the hospital and other health care providers.
- There were two reported serious incidents (SIs) in critical care services between November 2015 and October 2016. Of these, one was a health care associated infection and the other a venous thrombolytic embolism (deep vein blood clot).
- 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. Between November 2015 and October 2016, the trust reported no never events.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff understood their responsibilities with regard to the Duty of Candour legislation. The trust provided examples of letters of apology, explanations and offers to share the full investigation findings provided to a patient showing Duty of Candour processes being followed.

# Critical care

## Safety thermometer

- The safety thermometer data recorded the prevalence of patient harms nationally and provided immediate information and analysis for ward teams to monitor their performance in delivering harm free care. Safety thermometer information was displayed in all the units. This meant all staff, visitors and patients were informed of the service's safety history.
- Data from the Patient Safety Thermometer showed that the trust reported 15 pressure ulcers, no falls with harm and two catheter acquired urinary tract infections (CUTI's) between November 2015 and November 2016 in the critical care services.
- Safety thermometer data provided by the trust showed that for the period January to December 2016 there had been 100% harm free care to patients across all critical care services in September and November 2016. For the other months across all critical care service, 92% to 97% of patients received harm free care.

## Cleanliness, infection control and hygiene

- Staff followed the trust's infection prevention and control practices, with the exception of the decontamination of nebulisers. This differed slightly from the trust decontamination policy. A risk assessment for the process used on the critical care areas was completed, and kept under review, to identify if deviation from the trust policy posed any risk to patients.
- There were side rooms in all critical care areas, to reduce risk of spread of infection from infectious patients or to protect patients with altered immune systems. Not all had lobbies and airflow systems to help prevent the spread of airborne organisms. Staff felt assured that as the trust refurbished and developed units, isolation facilities would be updated to include such lobbies and systems.
- Despite the environment of GICU, Neuro ICU and SHDU posing a potential risk to effective infection prevention due to the close proximity of bed spaces, there was no evidence such as an increase of cross infection, to indicate this had a negative impact on infection control management in these areas.
- We observed staff adhered to infection prevention and control practices. This included using personal

protective equipment, such as gloves, aprons and eye protectors, washing their hands before and after any patient contact and wearing clothing that did not reach below the elbows.

- The trust provided us with the results of the monthly cleaning audits for all critical care areas. The trust's target for cleanliness was 98% percent or above compliance with their cleaning processes. Audits for the year 2016 showed that for clinical cleaning all areas generally scored 98% or above. Cleaning carried out by clinical staff consistently met the trust target of 98%. Cleaning carried out by the contracting company met the 98% target most of the time. There was one exception on CICU, two exceptions on the B side of GICU and one exception on SHDU. At no time did the compliance rate drop below 95%.
- In all areas, we observed the environment and equipment was visibly clean. Some units used "I am clean stickers" to identify when equipment was last cleaned.
- However, we saw in all areas, that equipment not being used was not covered to protect against build up of dust. This included essential ventilator equipment used during the transfer of patients. We escalated this at the time of the inspection, to the senior management of the hospital.

## Environment and equipment

- During the previous inspection in December 2014, we found some environment concerns. The electrical supply to GICU was frequently interrupted, and there was a lack of hoists and moving and handling equipment. There were also concerns on Neuro ICU about the provision of out of hours computerised tomography (CT) scanning, and a lack of assurance essential safety checks on electrical equipment had taken place.
- At this inspection we found that an uninterruptable power supply had been provided for GICU. Staff confirmed since the introduction of the uninterruptable power supply, there had been no incidents of interruptions to the supply.
- On GICU there were no reported concerns with the availability of moving and handling equipment. The trust had installed overhead gantry hoists, which meant they could now be used to move patients, including bariatric patients, whilst they were in bed.

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- The GICU also had two 'airpod' mattresses, (an air mattress that uses in-built, adaptive and self-regulating technology for the safe and efficient transfer and repositioning of patients), which enabled the safe transfer and movement of patients, and reduced the risks of injury to patients and staff working in constrained spaces.
- A portable head scanner had been purchased through charitable funds. The head scanner was stored in Neuro ICU and reduced the need for patients to be transported across the hospital out of hours.
- All equipment used in all the critical care units was standardised. As patients transferred between the different units, their supporting equipment went with them. This meant there was no risk in having monitoring and infusions temporarily discontinued whilst patients transferred to different equipment.
- At this inspection, we found that safety checks of electrical equipment were carried out in line with current guidance. The testing was managed by the clinical engineering department, who had recently changed the method of identifying on the equipment when it had been tested and when it was next due a test.
- However, on the critical care units, not all staff were clear what the details on the new labels meant. This meant staff based their assurance electrical equipment was safe to use on knowing the clinical engineering department managed the checks, rather than understanding how the labels on equipment identified whether equipment had been checked or not.
- The clinical engineering department used an accredited risk based maintenance programme to ensure all equipment used in the critical care services was maintained, working correctly and safe to use.
- The cramped environments of GICU, Neuro ICU and SHDU posed problems with storage of equipment. This meant equipment was stored away from the clinical areas, which had the potential risk of delaying treatment for patients when staff had to go off the unit to access equipment. However, there was no evidence of any negative impact on the wellbeing of patients or staff.
- Resuscitation equipment trolleys had tamper proof tags on them. The hospital policy was that staff checked the emergency equipment had not been tampered with daily and a full check of all equipment was carried out weekly. Records we viewed showed these checks were

carried out daily and weekly with the exception in GICU where for one day in January 2017 and two days in December 2016 staff had not signed the record to evidence the checks had been completed.

- Each level three area (GICU, Neuro ICU and CICU) had a difficult airway trolley. These were checked by staff weekly. Records we looked evidenced these were checked weekly.

## Medicines

- In the Neuro ICU, some medicines were stored in cupboards next to the patient's bed areas. In all areas, cupboards were used to store all or some of the medicines. In some areas, including CHDU, CICU, GICU and Neuro ICU some medicine cupboards were left unlocked. Risk assessments had been completed and were kept under review for this practice. It meant staff had immediate access to urgent medicines in an emergency situation.
- Controlled medicines were stored in line with trust policy and national guidance. Staff completed daily recorded stock checks of controlled medicines in all critical care areas. Staff on GICU told us about changes in practice that had resulted from review of incidents relating to the storage and recording of controlled medicines.
- On CHDU there were six sets of medicine cupboard keys. The environment of the ward meant that if there were less sets of keys, there was risk that patients would not get their medicines in a timely manner. Documented processes were followed to ensure all keys were handed over to oncoming staff at the change of shifts.
- Some medicines need to be stored in a specific range of temperatures in a medicine fridge to ensure their efficiency. Staff recorded maximum, minimum and actual medicine fridge temperatures daily. Across the units, there was variability in how these were recorded and whether action was taken if temperatures were outside recommend ranges. On some units, the temperatures were recorded on paper forms, which could then be filed for future reference. On other units, including GICU and CICU, temperatures were recorded for a month or two month period on a wipe clean form. At the end of the one or two month period, staff photocopied these forms so a paper copy was available for future reference.
- On CICU, the medicine fridge recording form detailed that the fridge temperature should be between 2 – 8

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degrees centigrade and that if the temperature was outside this range to follow the guidance overleaf. When we turned the record sheet over, there was no guidance to tell staff what to do.

- On CICU, for January 2017, the maximum fridge temperature was below 8 degrees centigrade on 7 and 8 January only. On all other days in January the temperature was recorded as above 8 degrees centigrade, the highest being 17.6 degrees centigrade.
- On GICU, medicine fridge temperatures were recorded as 9.1 degrees centigrade on 22 and 26 January 2017. There was no evidence in either CICU or GICU that action had been taken in response to these raised temperatures. When we asked a senior member of staff about the medicine fridges, they were not able to provide any assurance the fridge temperatures had been escalated.
- There was a consultant pharmacist who oversaw the critical care areas and pharmacists were directly allocated to the critical care areas. However, there was no dedicated pharmacist with critical care expertise at the weekends. The critical care staff had identified this as a risk to patients and this was included on the service's risk register. The risk register detailed actions that were being taken to lessen the risk, but showed there was a still a risk due to complex medication regimes not being reviewed over the weekend.
- All critical care areas had access to microbiologists, who also attended ward rounds. This helped to ensure the appropriate use of antibiotics to treat infections.

## Records

- Since the last inspection, electronic patient records had rolled out across the critical care services. At the time of inspection, electronic patient records were used in all critical care areas, with the exception of CHDU. Staff on CHDU told us they were working with the electronic record developers to ensure the system met the specific needs of their patients and the running of the unit before it was implemented on their unit.
- Each bed space had a dedicated computer where patients' records were entered.
- Most equipment used to support the patient, such as the ventilator, monitor and infusion pumps were connected to the system for recording.
- All medical and nursing notes were recorded in the electronic system. There were prompts for both medical and nursing assessments, care planning and risk assessment.
- All notes entered onto the electronic recording system were dated, timed and the name of the person entering the details was recorded.
- Staff told us the system was quick and intuitive to use. They felt the prompts for monitoring and attending to the patient enhanced patient safety. They felt the system helped to free up nursing time, giving more time for patient care rather than writing notes.
- We observed some practices that did not fully protect the confidentiality of patients. Although electronic notes were secure, we saw paper records not fully kept in a secure manner. We saw stacks of patient records on the nurses' station in CICU, that anybody walking through the unit could access. Patient notes folders were held on the computer stand by the patient. On the first day of the inspection we saw on CICU that these records were stored on the part of the stand that faced out to the corridor. We raised this with the trust who took action to minimise the risk.
- All units had white boards that, with the exception of RHDU, detailed the names of all patients in the unit. The trust had considered guidance provided by the National Information Governance Board in 2012 about this practice. Part of this guidance included carrying out of a privacy impact assessment. Staff told us the trust had carried out this assessment six years ago. They had concluded the practice was appropriate in order to support efficient service provision. The hospital gave patients an information leaflet before or on admission to the hospital. This informed them that staff would normally write their name on a white board above their bed and by the nurses' station. The information told them that if they had any concerns with this practice they should tell a member of staff. Staff told us that patients, on admission, were asked for their consent to display their names on the white boards. However, it was not clear what process took place when patients were admitted to the units in critical states and could not consent to have their name being displayed.
- On CHDU we viewed paper records for four patients. Despite there being two areas in their record where they could consent to have their names displayed, none were completed to evidence patients had given their consent.

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- On SHDU we saw theatre lists were pinned up on a notice board next to the entrance to the unit. This was in area easily visible to visitors. The theatre list detailed the names of patients and the procedure they were having.

## Safeguarding

- Data provided by the trust, showed that all staff were required to complete safeguarding adults training and child protection training level 2. 81% of all critical care medical staff had completed this training. This was below the trust target of 85% of staff completing the training. Following a trust review of the requirement for medical staff to complete child protection level 3 training, they identified that only one member of the critical care medical team needed this training. This member of staff had completed the training.
- However, 92% registered nurses, 88% of health care assistants and 78% of medical staff 78% had completed training on PREVENT (terrorism awareness).
- Staff demonstrated an understanding of safeguarding both adults and children and understood the process they needed to follow if there was a concern that an act of abuse may have occurred or that a patient was at risk of abuse.
- In SHDU posters were displayed giving information to staff and visitors about who to contact if they were concerned about abuse.

## Mandatory training

- Staff reported they could access electronic mandatory training both at work and at home.
- Training staff were required to complete included fire safety, moving and handling, health and safety, information governance, clinical resuscitation, food hygiene, conflict resolution and equality and diversity.
- The trust's target for compliance with each mandatory topic was for 85% of staff to have completed that training. Records provided by the trust showed that for all staff groups there were areas of the mandatory training where they were below the 85% target.
- For registered nurses out of 15 subjects, there were three subjects (child protection level 2, mental capacity act and safeguarding adults) where they were below the trust target. For health care assistants there were six out of 15 subjects (local induction, child protection level 2, conflict resolution, mental capacity act, safeguarding adults and clinical resuscitation) where they were below the 85% target.

- Data provided showed medical staff performed poorly with regard to mandatory training. Out of 15 subjects, they achieved the trust target for only 4, which were corporate induction, equality and diversity, health and safety and hand hygiene.

## Assessing and responding to patient risk

- An modified early warning scores (MEWS) system was used on the wards to monitor patients' health and identify patients whose health was deteriorating or at risk of deteriorating. Observations were electronically recorded on the records system and were accurate with readings taken directly from the machines.
- There was a critical care outreach team who provided a service throughout the hospital. Their role was to provide clinical support for patients on the wards requiring critical care interventions, education and support with managing patient care to ensure timely intervention and treatment of clinical deterioration in patients 24 hours a day. Two outreach nurses were on duty at all times. The outreach team were also part of the trust wide resuscitation team.
- The outreach team were the only practitioners outside the critical care units, who had the skills and authority to set up non-invasive ventilation on patients and care for them outside the critical care units. Critical care outreach staff told us that this practice had reduced the mortality rate for patients who required non-invasive ventilation before they were admitted to a critical care setting.
- All the critical care outreach nurses had completed specific training to give them extended scopes of practice. This included interpreting chest X-rays and blood results, carrying out peripheral cannulation, arterial blood gas analysis and making certain clinical decisions. They worked to directives to administer oxygen, saline and salbutamol nebulisers.
- At our inspection in December 2014, outreach staff were concerned that there was an inconsistent approach with departments accessing the outreach team in a timely and appropriate manner, with relevant information about the deteriorating patient. At this inspection, the outreach staff told us they had developed link roles with the ward areas. They were putting in place supportive education to the wards and medical teams so they had a good understanding about the role of the outreach team and when to contact them.

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- To support safe discharges from GICU, the outreach team reviewed all discharge information and assisted with the discharge. This helped to ensure staff on the receiving ward had all the information they needed to continue the care and treatment of the patient safely.
- There was a research area in the hospital where members of the public could take part in clinical trials. The research facility notified the outreach team if they were remaining open outside their normal hours to ensure patient safety.
- At the previous inspection outreach staff said that, if a patient needed admitting to a critical care bed, the procedure required a consultant to consultant referral. Since the inspection, the procedure had been reviewed and outreach staff were now able to refer directly to the critical care consultants. This meant one of the outreach nurses was no longer occupied caring for the deteriorating patient for lengthy periods of time, resulting in reduced resources to attend to other deteriorating patients in the hospital.
- There was a clinical psychologist attached to the critical care services, who could provide psychological support to patients who required it. Staff we spoke with knew the process to access mental health support for patients.

## Nursing staffing

- There were shortages in the numbers of permanent staff. Figures for December 2016 showed that for GICU there was vacancy rate of 14%, CICU a vacancy rate of 10%, Neuro ICU a vacancy rate of 11%, CHDU a vacancy rate of 8% and SHDU a vacancy rate of 6.5%. The same data showed that by February 2017, with the recruitment of new staff, the vacancy rate would have decreased to 10% or below for all areas, with GICU having a 4% vacancy rate and CICU a 1% vacancy rate.
- The trust showed the need to use agency staff had steadily decreased between the months of October 2016 to January 2017. In October 2016 there were 919 requested shifts compared to 585 shifts in January 2017. The total fill rates for requested agency staff increased during the same period. In October 2016, the fill rate was 57.8%, in January 2017 the fill rate was 70.9%.
- Data for the months, September, October, November and December 2016 provided by the trust showed that overall Neuro ICU, GICU and CICU met their planned staffing levels. However, for the same period SHDU marginally failed to meet their planned staffing levels.

- The trust told us that whilst there were deficits in the percentage of unfilled shifts across critical care service, the staffing ethos was to utilise the workforce flexibly across all units to ensure patient safety was maintained. Staff confirmed that at times of staff shortages they worked across the critical care service, including those in different divisions than their normal place of work, to ensure patient safety was maintained.
- Staff undertook core competencies to support and underpin their critical care knowledge and skills. These skills were transferrable across all the critical care areas. Staff confirmed the critical care service worked together to cover shifts that were not filled by agency staff, with staff working in units other than their main unit of work. The units also utilised critical care band 4 support workers to care for an appropriate level of patients overseen by qualified nurses. This involved band 4 staff caring for a stable level 2 patient or level 1 patients waiting for beds on the general wards.

## Medical staffing

- All critical care areas met the medical staff guidelines set out in the National Core Standards for Intensive Care Units.
- Consultant intensivists worked in blocks of short days in line with the core standards. They found this meant they worked more effectively and efficiently.
- There was no Neuro ICU intensivist on duty at night, (11pm to 7.00am). This was entered as a risk on the critical care services risk register, which detailed the action taken to mitigate any risks. To mitigate risk to patients, the day hours of intensivists were extended and planned extubations occurred during the day when there was appropriate emergency assistance available.
- There was an on call consultant anaesthetist out of hours from 11pm to 7.45am in the hospital every night, that Neuro ICU staff could access for support. There was a clinical fellow onsite during out of hours, some of whom had anaesthetic experience.
- All senior nursing staff working in Neuro ICU had completed Advanced Life Support training and were skilled in airway management. There was also sufficient airway competent medical staff in GICU and CICU to support Neuro ICU if needed. There had been no reported incidents since the opening of the unit that related to lack of intensivist cover on the unit at night, but the risk was kept continually under review.

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- In Neuro ICU there were physician assistants. These members of staff, were previously operating department assistants, The trust had trained and assessed them as competent to insert central lines, arterial lines and intracranial pressure monitors.
- On CICU and GICU intensivist cover fully met the national guidelines. Any gaps in the rotas due to, for example illness, were covered by their own staff. There was no locum or temporary medical staff.
- The GICU intensivists managed all the patients on SHDU for their respiratory and post anaesthetic care, with their surgical care managed by their surgical consultants.
- Middle grade medical staff staffed RHDU. At night, the hospital at night and on call physicians were responsible for care of patients on RHDU. To mitigate any risk for patients receiving non-invasive ventilator support being managed but general physicians detailed written handover plans were prepared to give clear guidelines and instructions to the local medical staff regarding the management of each patient. Staff on RHDU could also access medical staff on GICU and the outreach team for support and assistance at any time.
- Recruitment and retention of middle grade doctors was managed well. This was seen to be due to the comprehensive and effective training programme put in place for middle grade doctors.

## Major incident awareness and training

- Staff in all units were aware of the trusts major incident procedure and where to access the information if needed.
- The critical care service business plan identified risks that related to business continuity and detailed the actions staff needed to take to mitigate these risks.
- Major incident scenarios were carried out. The last one was a table top exercise in June 2016. This was led by the trust's Emergency Planning team and ran through scenarios to test how critical care services would respond in the event of several scenarios. The report of this exercise indicated that critical care services had a and well organised plan of deal with any eventualities that may happen. The report detailed "those attending were very knowledgeable and are fully aware of what would be required of them to ensure patient safety."

- Nurse agency induction processes included information about local major incident plans and the action they would need to take in the event of a major incident occurring.

## Are critical care services effective?

Good



We rated effective as good because:

- Treatment and care followed current evidence based guidelines.
- Critical care services participated in national and local audits to measure their effectiveness. Data from audits showed there were good outcomes for patients treated by the critical care services.
- There was a highly effective education programme, managed by a dedicated nurse education team, for nursing staff working at all grades. The delivery of the education programme mitigated risks associated with less than 50% of the qualified nurses having a post registration qualification in critical care nursing.
- There was also an effective education programme for medical staff, which supported the service to recruit and retain medical staff.
- Multidisciplinary working was evident in all critical care units. Patients were followed up when they were discharged from critical care services to the wards and when they were discharged from the hospital.
- Staff showed a good understanding of the Mental Capacity Act, and how it related to their working practices.
- There was evidence that both formal and informal consent was obtained, and that best interest decision making processes took place.

However:

- There was no dedicated critical care pharmacist on duty at weekends.
- Discharge summaries produced from the electronic record system, only provided information about the patients current care and treatment on ongoing treatment plans.

## Evidence-based care and treatment

- The critical care services care practices followed current evidence based guidance. Care plans referenced best

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practice guidance published by the National Institute for Health and Care Excellence (NICE), intensive care society standards and National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

- In line with national guidance and best practice, patients had a rehabilitation assessment completed within 24 hours of admission to critical care service.
- In line with NICE guidance (CG83), patients discharged from the critical care services, had access to follow up clinics or services.
- National recognised care bundles were followed. These included care bundles to reduce the risk of ventilator acquired infections, central line infections and complications and management of sepsis.
- Critical care service took part in a number of national audits to measure the effectiveness of the care and treatment provided. This included the National Cardiac Arrest audit, Intensive Care National Audit and Research Centre (ICNARC) and the Society for Cardiothoracic Surgery. Neuro ICU were progressing with submission of their data to the neurological data base for ICNARC.
- Local audits included the number of out of hours discharges from critical care services, compliance with infection control practices and care bundles and compliance with the NICE critical care rehabilitation guidelines. Matrons, or other relevant clinicians, identified follow up actions and monitored those areas with sub optimal performance.

## Pain relief

- Patient's pain and response to pain were monitored as part of their routine observations.
- Staff demonstrated in conversations a good understanding about identifying pain from non verbal signs, including changes in vital signs observations in patients who were sedated and ventilated or who had other communication difficulties.
- Pain control was considered during ward rounds, with prescription of medicines adjusted accordingly.
- A nurse specialist in pain control was contactable by telephone for advice, and would see a patient if asked.
- The link palliative care consultant, provided advice and support regrading pain relief for patients.

## Nutrition and hydration

- All patients had assessments completed about their nutritional and hydration needs, and their risk of malnutrition. Protocols and policies were followed regrading enteral and parenteral feeding practice.
- Critical care pharmacists monitored the prescribing and making up of parenteral nutrition (nutrition provided to patients through their veins) to ensure it was safe for patients.
- Speech and language therapists were available to check that patients were safe to swallow. For patients assessed as having an unsafe swallow, speech and language therapists provided guidance about how to support the patient with eating and drinking.
- At the previous inspection, access to a dietician for patients in Neuro ICU was slightly fragmented, with no dedicated dietician for the unit, other than for those patients who had a head injury. Since that inspection, the dietetic provision in the hospital had been reviewed and restructured providing dedicated dietetic support for Neuro ICU and other critical care units.
- Nutrition and hydration was monitored with the use of the electronic recording system or paper records.

## Patient outcomes

- The trust had one unit (GICU which included data form SHDU) which contributed to the Intensive Care National Audit Research Centre (ICNARC). This meant that the outcomes of care delivered and patient mortality were benchmarked against similar units nationwide. The data form the November 2016 report showed good outcomes comparable to other similar services. Despite the poor infrastructure and facilities of GICU and SHDU, the ICNARC report did not show higher rates of infection nor higher mortality.
- Data provided by the early mobilisation programme in GICU showed the programme reduced patient's length of stay in GICU by up to two days.
- The most recent national audit for neuro critical care carried out in 2013 showed that at that time outcomes for patients with head injuries treated in Neuro ICU were better than the national average. Neuro ICU was in the process of starting to submit data to the Neuro Intensive Care National Audit Research Centre in order to benchmark themselves against other similar units.

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- Data from the Society for Cardiothoracic Surgery showed that for the period April 2012 to March 2015, 3,615 cardiothoracic operations were carried out at the hospital with a mortality rate of 1.49%. This was better than the national expected rate.

## Competent staff

- Throughout the critical care service, nurse staffing did not entirely meet the recommended 50% of all nurses having a post registration qualification in critical care nursing. However, a highly effective nurse education team ensured all staff had appropriate training to equip them with the skills to be competent critical care nurses, including competencies to use role specific equipment.
- Dedicated nurse educators, who had links with the local university, worked across CICU, Neuro ICU, GICU and SHDU to provide training for all levels of nursing staff across all these units. A structured development framework for all nursing staff included completion of the National Competency Framework for Registered Nurses in Adult Critical Care; developed by the Critical Care National Network Nurse Leads.
- The development framework supported staff to further develop their skills by accessing the foundation course in critical care nursing, mentoring courses, leadership courses, in charge competencies as well as support to take on specific roles in the units such as clinical educators, project leaders and team day leaders. Staff working in Neuro ICU were supported by the nurse educators and the nurse educator attached to the neurosciences unit, to complete the neurosciences nursing course.
- The nurse educators supported band 2 and 3 health care assistants' development programmes. This included supporting band 2 and 3 health care assistants with completing the national care certificate, vocational qualifications, apprenticeship roles and training and supporting some through courses to become registered nurses.
- There was a structured development programme for nurses working on CHDU, which worked through the competencies of staff in caring for patients with less acute needs, to those who were ventilated following cardiac surgery. For those staff who did not want to progress their nursing career any further, the education team arranged refresher study days, to ensure staff were up to date with current guidance and knowledge.
- On RHDU, a member of staff was allocated part time nurse educator hours. There was a mandatory structured competency framework and, although not part of the main critical care service, staff were able to access the critical care education team for specific training they required.
- Nurse educators explained that the development pathways supported staff to compile the evidence required for revalidation with the Nursing and Midwifery Council (NMC).
- All nursing staff we spoke with, spoke highly about the support provided by the education teams, and expressed the education programme was an important factor in their decisions to work in the critical care services.
- Staff confirmed they received regular supervision sessions from their line managers.
- Medical staff spoke positively about the training and support they received whilst working in the critical care services. A planned weekly training programme provided structured training for all medical staff across the service. Middle grade doctors we spoke with told us that the reputation for training had attracted them to apply to work at the trust.
- The trust provided data about the appraisal rate for staff working in the critical care service. This showed that at the time of inspection that only CICU and RHDU had met the trust target of 92% of staff having had an annual appraisal. SHDU had an appraisal rate of 77%, with GICU, Neuro ICU and the outreach team an appraisal rate of 86%. It was not clear from this data whether it related to nursing and medical staff, or just nursing or just medical staff.
- Induction programmes relevant to their roles, were completed by all new staff, medical and nursing. Agency and bank nurses completed an induction checklist when working on the units.
- Allied health professionals, including physiotherapists, occupational therapists and pharmacists, told us they completed mandatory training and received supervision from their line managers.

## Multidisciplinary working

- There was evidence of multidisciplinary working in all critical care areas. This included physiotherapists, occupational therapists, dieticians and speech and language therapists.

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- In all units, technical staff supported staff with the management of equipment. In Neuro ICU technicians provided support for all patient transfers, both between departments in the hospital or out of the hospital.
- In RHDU, the physiotherapy team was closely involved in plans to wean patients from long term ventilation. They coordinated the discharge of patients requiring long term home ventilation, to ensure the community physiotherapy and nursing teams and family members knew how to provide safe care to the patient.
- Staff in Neuro ICU worked with the specialist clinical neurophysiology team for specialist monitoring of patients such as nerve conduction measurements and electromyography.
- All units worked closely with the specialist nurse for organ donation, who was based in Neuro ICU, to provide support for families whose relative wished to donate organs in the event of their death.
- The critical care service worked closely with the palliative care team to provide timely and empathetic support for patients whose conditions would not improve. A palliative care consultant was attached to GICU and attended ward rounds to support identification of patients who required palliative care and provide advice about symptom control and management. This service, in supporting decision making, had enabled 200 patients to appropriately enter an End of Life care pathway.

## Seven-day services

- A physiotherapy service was available across all critical care services 24 hours a day. An on call service was used out of hours and at weekends. Staff said there was no delay in accessing physiotherapy support for patients out of hours and at weekends.
- Critical Care service had access to a dedicated pharmacist during weekdays. However, the number of pharmacists dedicated to the critical care areas was 4.1 whole time equivalent (WTE). This did not meet the standards of the Royal Pharmaceutical Society or the Core Standards for Intensive Care Units. An on call pharmacy team, who might not have critical care experience, provided pharmacy support out of hours and at weekends.
- Pathology services were available seven days a week, with the out of hours service being an on call service.
- Imaging (Xray) services were available 24 hours a day, seven days a week.

## Access to information

- All areas used electronic handover sheets to ensure all staff (nursing, medical and therapy staff) had up to date information about patients in their units.
- Discharge forms were printed from the electronic record system. Staff had identified that this process meant that the wards did not always receive a full history of the patient's journey, treatment and wellbeing whilst in hospital. To lessen any risk this posed, verbal handovers from nurse to nurse, medical staff to medical staff and therapy staff to therapy staff took place.
- All staff had personal log in details for the electronic recording system, ensuring information was secure and remained confidential. Agency staff who worked on the units, completed specific training and received a personal log in to the system, so they could carry out their role effectively.
- The nature of the work on CHDU meant there was a fast turnover of patients admitted and discharged to other wards in the hospital. To reduce the impact of lack of information at discharge they were working with the electronic recording system developer to improve the discharge information, before introducing the system to their unit.
- Staff on all units told us they had the opportunity to work with the developers to ensure the system met the needs of the patients and staff.
- There were back up systems to ensure data was not lost and processes were in place to ensure monitoring was recorded in the event of power outages.

## Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Where possible, staff asked patient's for their consent before delivering any care or treatment, with staff acting in accordance with patient's wishes. Patient records showed both formal and informal consent were sought from them, dependant on the care or treatment being given.
- Training about the Mental Capacity Act and associated Deprivation of Liberty Safeguards was part of the trust's mandatory training programme. Records provided by the trust showed that no staff group achieved the trust 85% of staff completing this training. Registered nurses had achieved 91% compliance, health care workers 66% and medical staff in critical care services 71% with this training.

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- However, conversations with staff demonstrated a good understanding of the Mental Capacity Act. There was evidence in patient records of best interest decision making processes being followed.

## Are critical care services caring?

Outstanding



We rated caring as outstanding because:

- Staff treated patients and their relatives with compassion, dignity and respect.
- Patients and relatives we spoke with were consistently complimentary about the care and support they received. They were also positive about the staff approach to promoting their privacy and dignity.
- Relatives told us staff were all very good and very helpful and that staff kept them informed about what was going on.
- Patients who we were able to have conversations with felt they were well informed and involved in the decision making process regarding their treatment.
- We observed staff speaking with patients and their relatives in a caring and compassionate manner.
- We observed staff explaining to patients and their relatives the care and treatment that was being provided in, order to reduce any anxiety.
- Patients told us their faith and spiritual needs were respected by staff, including enabling them to have items of faith or religious significance with them at all times
- People's emotional needs were highly valued by staff and were embedded into their care and treatment.
- Nursing staff kept patient diaries by their bedside outlining what events had taken place while the patient was ventilated (and therefore not conscious) or unconscious for other reasons. Relatives also made entries in the diaries. These helped patients fill in the missing gaps in their lives during their stay in the critical care units.
- Relatives told us staff were all very good and very helpful and that staff kept them informed about what was going on.
- We observed staff speaking with patients and their relatives in a caring and compassionate manner.
- Thank you cards and letters from patients and their relatives were displayed in the units. Comments from thankyou cards and letters included "The nursing staff - wow! So caring and installed us with so much confidence", "I was truly impressed by their dedication and commitment, their professionalism in caring not just for the medical needs, but also the dignity and general wellbeing even though [the patient was] often not conscious",
- Other comments included, "At a very traumatic time for all the family we were treated quite brilliantly by all your staff. The politeness, professionalism and sheer skill we were shown impressed us hugely. Not only the immediate team of surgeons, intensive care doctors, nurses and support staff but also even the staff and porters in the corridors were all so helpful to us hopelessly lost in the maze of corridors!", and "Physios on HDU- Amazing. How did they get him out of bed the very next day with such humour and compassion?"
- Patients said they felt safe and secure with the care and treatment on the units.

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

### Compassionate care

- Patients and relatives we spoke with were very complimentary about the care and support they received. They were also positive about the staff approach to promoting their privacy and dignity.

- Patients who we were able to have conversations with felt they were well informed and involved in the decision making process regarding their treatment.
- Relatives felt they were fully informed about their family member's treatment and care. They said staff checked whether they wanted to be contacted during the night with any changes in the patient's condition and their wishes were respected.
- Both patients and their relatives commented that information was discussed in a manner they understood.
- We observed staff explaining to patients and their relatives the care and treatment that was being provided in, order to reduce any anxiety. Patients and relatives told us staff in the units were very supportive, and that explanations about equipment was helping to reduce their anxiety.
- We observed an intensivist on CHDU explaining to a patient in a clear and gentle manner the need to wear a

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specific oxygen mask, explain the reason why, that would help them get better sooner, but at all times explaining to the patient that it was their choice whether to wear the oxygen mask.

- The specialist nurse for organ donation, who was based in Neuro ICU. The nurses supported families and staff through the organ donation process, which included completing last offices, taking hair locks or hand prints for memory boxes and following up with families once the retrieval had been completed.

## Emotional support

- Patients' emotional needs were highly valued by staff and were embedded into their care and treatment.
- Patients and relatives we spoke with said the care and support staff gave to them, also supported them with their emotional needs. Feedback from patients received by the critical care service included, "The care we received. Not only as a patient but our whole group of family and friends was first class, as has the follow up care that we have received."
- In Neuro ICU, patient profiles including information about their personal, social and family life was completed. This meant that staff could talk with and engage the patients in topics they were interested in, even when they were unconscious or did not appear to be listening or understanding.
- In GICU and Neuro ICU nursing staff kept patient diaries by their bedside outlining what events had taken place while the patient was ventilated (and therefore not conscious) or unconscious for other reasons. Relatives also made entries in the diaries. These helped patients fill in the missing gaps in their lives during their stay in the critical care units; especially those who had been in a coma. Once they had recovered, the completed diary, which remained the property of the patient, was returned to them if desired to understand their treatment and how everyone was involved fully in their care.
- Patients identified as requiring long term treatment and care in CICU, along with their families, had a consultation with a band 7 nurse on alternate days to ensure families and patients had continuity of information and support following discharge.
- Emotional support for patients and their families was available from the trust chaplaincy team who would provide support for patients of all faiths and those who did not have a faith.

- Patients told us their faith and spiritual needs were respected by staff, including enabling them to have items of faith or religious significance with them at all times.
- Close working with the organ donation coordinators across all the units, provided emotional support to families regarding organ donation.
- A palliative care consultant was attached to GICU. This helped to support families, and where possible patients, with making difficult decision and had enabled 200 patients to choose an End of Life care pathway.

## Are critical care services responsive?

Good



We rated responsive as good because:

- A strategic plan had been developed by the trust and was being followed to increase the critical care bed capacity in the hospital.
- The individual needs of patients with a learning disability, living with dementia or who had a mental health need were considered. Where appropriate, reasonable adjustments to delivery of care were made, and staff knew how to access specialist support and advice.
- Despite access and patients' flow in and out of the units being a daily challenge, access and flow of patients in the service was better than that of similar units.
- The service responded to concerns and complaints. Where appropriate and possible, the service made changes to practices in response to concerns and complaints.
- Bed occupancy was within the expected range of other similar units across England, though occupancy was above 70% on average.

However:

- The environment of some of the critical care areas posed challenges with meeting the individual needs of patients and their families. Mixed sex breaches for level 1 patients who discharges from critical care were delayed, were not monitored or declared.
- The environment of Neuro ICU was not appropriate for discussing difficult news with relatives.
- Some people may find information on the hospital website inaccessible.

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## Service planning and delivery to meet the needs of local people

- The critical care units provided a service for patients undergoing elective and emergency cardiac, general and neurosurgical procedure as well as treatment for patients with medical conditions, including respiratory conditions.
- The hospital was a regional major trauma centre and a regional neurological centre. This meant the units treated critically injured emergency patients. CICU was a regional centre for cardiac intensive care and predominantly admitted patients following elective cardiac surgery.
- The trust had identified that with the development of new techniques and the hospital's position as a major trauma centre the demand for critical care beds was increasing. Work was commencing the week after our inspection to expand SHDU, by two beds to ten beds with increased storage areas.
- Expansion plans for GICU were at an advanced stage, with the staff being consulted on the design and what they needed from a new intensive care unit. The development of GICU was planned to bring the environment in line with the current hospital building notices for critical care units and to increase the capacity by a minimum of four beds. The expansion of GICU was planned to be delivered within three years.
- Plans for the development and expansion of all areas, took into consideration the associated requirement to increase staffing in all of these areas.
- CICU, whose work was predominantly planned surgery, had two supernumerary nurses on duty in the morning. One to coordinate the flow of patients in and out of the unit and the second to coordinate the care of patients, in the afternoon when patients returned to the unit from theatres the nurse who had coordinated the flow of patients, took on the role of caring for patients, leaving one nurse to coordinate the unit.

## Meeting people's individual needs

- Delays in discharge from level 2 beds meant that for level 1 patients there was a risk they would be nursed in mixed sex areas that did not effectively maintain their privacy and dignity. Staff said if a level 1 patient had to

stay in the unit for a prolonged period of time, they would consider bed moves across the unit, to promote single sex areas, and protect patients from observing distressing scenes.

- Toileting and bathing facilities in the critical care units was not appropriate to meet the needs of patients receiving level 1 care. There was no process followed to monitor mixed sex breaches in the critical care units. This meant the service could not identify the frequency this occurred and the relevant data was not provided to the Department of Health who monitored mixed sex breaches across the whole of England.
- The environment of Neuro ICU was not appropriate for discussing difficult news with relatives Staff told us there were insufficient facilities to accommodate the number of grieving and distressed relatives to have quiet and /confidential conversations. This was detailed on the divisions risk register, which included the action staff were presently taking to address this concern. Actions included staff vacating offices to provide room to talk with relatives, asking relatives to leave one area to free room for another set of relatives and the use of corridors to have conversations with relatives.
- Although training records provided by the trust, did not indicate staff received training about supporting people with a learning disability or dementia, conversations with staff showed they had an understanding of caring for patients with a dementia or a learning disability, including involving the patient's relatives or carers in the delivery of care.
- Staff on all units knew there was a learning disability team they could access for advice and support, when caring for patients with a learning disability.
- Some patients undergoing cardiac surgery who were being treated in CICU and CHDU had a learning disability associated with their congenital cardiac condition. Staff spoke about reasonable adjustments being made to support these patients. This included nursing the patient in a side room so their relatives and carers could support them. The preadmission assessment processes for elective patients meant their needs and required adjustments were known before they were admitted to the unit.
- We spoke with the parents of one patient with a learning disability who was being treated on CICU. They told us they could visit the unit at any time of day or night. However, the mother, who was the main carer for the

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patient, commented that she felt a bit left out, as staff did not involve her in delivering personal care, such as washing, to her son or daughter. This was a task she normally carried out for her son/daughter every day when they were well at home.

- In Neuro ICU, there was guidance developed by one of the nurses, about how to meet the needs of patients who exhibited challenging behaviours as a result of their neurological injury and impairment.
- Information was available in leaflet format and on notice boards in the units for patients and visitors to view. Information about the trust's critical care services was also available on the trust's internet site. However, the information on the website was not easily accessible to people who had any difficulties reading written literature. There was no way to enlarge the writing for people who had visual difficulties. This meant some people might find the information inaccessible.
- All critical care areas had a follow-up service for patients once they had been discharged from the hospital. GICU ran follow up clinics to support patients with their physical and emotional recovery. This was only offered to patients who had three or more days level 3 care and treatment in GICU.
- Psychology input was available for those patients who needed it. Staff told us the use of telephone consultations meant follow up support was received sooner and by more patients than previously. At the previous inspection, only the consultant input into the follow up service had not been funded and their service at that time was provided voluntarily. At this inspection, we were told that the consultant input into the follow up clinic was now funded and did not have to be provided voluntarily.
- The cardiac rehabilitation team provided support to patients following cardiac surgery and cardiac events. This included support with emotional needs, which could include signposting the patient to other support organisations and professionals.
- In Neuro ICU, there were specialist nurses who followed up patients discharged from the unit. They were also involved in providing support to both the patient and their family during their stay in Neuro ICU. Specialist nurses included traumatic brain injury and subarachnoid haemorrhage nurses. Neuro ICU had specialist nurse contacts at the nearby specialist spinal injury unit to access specialist and follow up support for patients.

## Access and flow

- Access and flow, in and out of the units provided challenge for the service. The nationally agreed standards for critical care state that discharges from critical care should occur within four hours of the decision that the patient no longer requires level 2 or 3 care.
- The critical care leadership team said the trust was paying more consideration to the patient flow through the critical care units. The trust understood that if there were no available critical care beds, patient operations were cancelled, which had a potential negative impact, both physically and emotionally, for patients.
- Bed flow through the critical care services was similar to or better than the national average. Publicly available data showed that in line with similar units, bed occupancy was above the recommended rate of 70%.
- Between November 2015 and October 2016, the trust has seen adult bed occupancy stay above 80% with the exception of a drop in December 2015 to 73.3%, which was similar to the England average. Data provided by the trust showed that bed occupancy for the period April to December 2016 ranged between 96% and 108% for GICU, between 78% and 103% for CICU and for Neuro ICU.
- Data from ICNARC for GICU and SHDU showed between November 2015 and November 2016 showed the percentage of bed days occupied by patients whose discharge was delayed more than eight hours was 4.6%. This was better than the national average of 5.2%.
- The number of delayed discharges over 24 hours was also better than those of similar units.
- The ICNARC report dated November 2016 showed for GICU and SHDU, there had only been two non clinical transfers out of the unit, which equated to 0.3% of eligible admissions. This was better than the national average of 0.4% in similar units.
- For the period April to December 2016 there were a total of 1211 admissions to GICU of which there were no non clinical transfer out of the unit. Between April and December 2016 on CICU there were a total of 1056 admissions with no non clinical transfers out of the unit.
- The data for GICU and SHDU showed that 2.8% of admissions were non delayed, out-of-hours discharges to the ward. These were discharges, which took place between 10:00pm and 6:59am. Compared with other units, this unit was within the expected range.

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- Neuro ICU, in line with national guidelines to promote the best possible outcomes for patients, accepted patients for emergency treatment regardless of whether they had a bed available at that time. This consequently posed a challenge to patient flow within the unit.
- Patient flow in Neuro ICU was also challenged by difficulties accessing ambulance transport to repatriate patients to their referring NHS trusts. To overcome this challenge, Neuro ICU had a contract agreement with an independent ambulance provider to repatriate their patients and enable patient flow through the unit.
- There was far sighted and highly effective leadership of the critical care services and the individual units. Within the service, although staff worked on separate units, there was an overarching ethos of working for one critical care service. At time of staff shortages, staff worked across the units to ensure a safe critical care service was delivered across the hospital.
- Staff were supported to develop leadership skills.
- Views of patients and relatives were considered at follow up appointments and changes made to the service where possible.
- Innovative ideas and approaches to care were encouraged and supported.
- Staff told us they felt supported clinically, psychologically and educationally.

## Learning from complaints and concerns

- Complaints were monitored and reported on monthly. There had been three formal complaints in the last quarter. There were no themes from the complaints.
- Staff understood the hospital's complaints policy and knew how to manage any complaints they received. They all said they would try to resolve any concerns or complaints that a patient might have before they escalated into a formal complaint.
- Information about the complaints process were displayed in the unit areas.
- Patients and relatives said they would voice concerns or complaints to the nurse in charge of the shift or the nurse caring for them. They were confident that concerns and complaints would be treated seriously and dealt with promptly.
- Records were kept in the units about any complaints received and resolved locally without being escalated into the trusts formal complaints process.
- Discussion with staff and review of records showed complaints were managed locally in an appropriate manner and learning and changes in practice made if necessary.

## Leadership of service

- The divisional structure for critical care was led by a Divisional Clinical Director, Divisional Head Nurse, and a Divisional Head of Operations. All the intensive care units (GICU, CICU and Neuro ICU), SHDU and the critical care outreach team formed the Critical Care Group of Division A of the hospital structure
- The CHDU and RHDU were led by the management structure of the cardiovascular and thoracic care group in division D and the medicine care group in division B respectively. Although these two units were led by separate hospital divisions and care groups, all staff reported effective team working across all the critical care services, which promoted effective and joined up leadership across all the services.
- Within the critical care structure each unit was led by a clinical lead and matron.
- There was effective leadership of the critical care services and the individual units.
- Staff in all the critical care units spoke highly about their local leadership and the trust leadership. They said they had exceptional leaders, who provided educational, psychological and social support for staff as well as the required clinical support. They said their managers were very approachable and provided clear guidance.
- At the previous inspection, critical care services did not have confidence that the trust senior management and executive team understood the significant challenges posed to the delivery of the critical care service. They

## Are critical care services well-led?

Outstanding



We rated well-led as outstanding because:

- There was a clear vision and strategic direction of the service, that all staff worked towards.
- Governance processes appropriately managed quality and risks issues, promoted reviews of the service provision and identified areas for improvement.

# Critical care

did not feel listened to. At this inspection critical care staff reported that the senior management team now listened to the concerns, views, and opinions of the critical care staff.

- The teams felt the executive team now valued the contribution the critical care team provided to the hospital. Medical staff told us that since the previous inspection, management attitudes had completely changed, demonstrated by the fact there was now a formal plan for rebuilding the main GICU over the next four years.
- Leadership training was available to equip staff with the skills to lead teams. Staff spoke positively about the training, and how it had supported them to develop their leadership skills.
- Patient and relative feedback to the service showed a belief that the service was well led. One relative commenting about the professionalism and politeness of all staff they came into contact with said, "In my experience, attitudes like they employed come only from the example set by the very top."

## Vision and strategy for this service

- There was a critical care clinical strategy and vision. The vision was detailed as 'Continue to be a leading provider of critical care service for both adults and paediatrics within the UK, through the delivery of excellent care and high quality outcomes. Continuously improve and innovate pathways, as well as support research and development. Aim to integrate staffing models and co-locate services where they optimise service provision and benefit patient flow.'
- The strategy set out the strategic objectives to deliver high quality clinical outcomes, provide excellent patient, family and staff experience and improve operational performance, along with a detailed description of the present challenges and risks.
- Staff knew about the vision and the strategic plans for the units, which include the redevelopment of GICU and increases in number of beds for all units. Staff expressed confidence that the strategy and the development and expansion of the critical care services would be delivered. Staff working on SHDU could see this was already occurring.
- Although CHDU and RHU were not part of the same division as the other critical care services, the Critical Care Clinical Strategy included these areas, and reviewed their environment.

- Staff expressed that the attention paid to the provision of education and professional development across all disciplines, demonstrated the services commitment to the vision and strategic objectives of the service.
- Locally developed visions and philosophies of care were displayed in the units.
- The visions, strategic plans and philosophies of care described by the service and individual units all displayed the trust's values and visions which were, 'Patients first, Working together and Always improving'.

## Governance, risk management and quality measurement

- Matrons and clinicians attended critical care governance meetings from GICU, CICU, Neuro ICU and SHDU. Staff and clinicians from RHU attended the respiratory medicine governance meetings and staff and clinicians from CHDU attended the cardiothoracic governance meetings.
- Records of governance meetings showed that risks to the service, significant events in both critical care and other areas of the hospital, finances for the trust and the critical care services, education, HR issues, clinical effectiveness were discussed. There was detail about actions required and who was responsible for them.
- Separate risk register review meetings were held monthly to review and monitor the risks detailed on the risk register, identify any further actions and assess any recently identified risks added to the register.
- Divisional risk registers identified risks associated with the service and mitigating action that was presently being taken and proposed action including timescales and the person responsible for the action.
- When we discussed risks to the service with staff, the risks they identified reflected the risks detailed on the divisions' risk register. Staff knew about the actions that were being taken to mitigate risks detailed on the risk register.
- All units had meeting where staff were updated about information from clinical governance meetings. These included information about complaints, incident and audits. Some units found that because of the number of staff employed it was difficult to hold meetings that all could attend. Newsletters, discussions at handover periods and during staff one to one meetings, and email correspondence meant all staff received this information.

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- Peer reviews were carried out. These asked the questions whether the units were welcoming, safe, caring and well organised. Records from peer reviews showed that areas identified as requiring improvements were acted on.

## Culture within the service

- Staff in all units spoke positively about the service they provided for patients. They felt the ethos and values of the units replicated the values of the trust.
- The management of critical care services demonstrated a caring and supportive culture towards staff, acknowledging the wellbeing of staff was essential to the running of the service.
- The service ran a “Fabulous Friday” across all units. This was a free draw for all staff of all disciplines, the winners of which won a gift voucher.
- In Neuro ICU, to recognise the commitment of staff, the clinical lead provided a subscription to online service which staff could use during their meal breaks. Previously the clinical lead had purchased pizzas for all staff working night shifts.
- Neuro ICU, acknowledging the impact difficult situations had on the mental health and wellbeing of staff, ran debriefing sessions with staff a few weeks after the event. These sessions were not to review the clinical care and treatment, but provide an opportunity for staff to express how the event affected their thoughts, feelings and wellbeing. A psychologist who was working with the service for a trial period supported these sessions.
- CICU demonstrated a commitment to working together as a team for charity work. Challenges they had completed included completing the Three Peaks challenge and climbing Snowden.
- Staff described a working practice across the service of being open and transparent with patients.
- The culture of the service supported collaborative working across all the critical care units. All units supported each other to ensure patients received safe and effective care and treatment. This included staff working across the critical care services to ensure safe staffing levels were maintained, shared learning across all units including learning from incidents and professional development provided by the nurse educators across the units.

## Public engagement

- Patient and family feedback about the service was gathered with the use of satisfaction surveys. Most of the units displayed feedback form the NHS Friends and Family Test and satisfaction surveys, and outline action they were taking to address any issues that had arisen from the results.
- Innovatively, the management team, with the support of the hospital media team, were looking at how to raise the profile of critical care services within the local population.
- Charitable organisations and support groups set up by patients and relatives who had used the critical care services supported the work of the services. They assisted with raising the profile of the critical care services, raised funds to provide equipment and provided support groups for patients and their relatives.

## Staff engagement

- Staff told us that meetings and handover sessions were used to keep them informed and involved in the running of the critical care service and the hospital. They felt the structured management and governance processes meant the senior management and executive team heard their views.
- Each unit developed their own processes for ensuring effective engagement with their staff team. For example, GICU had a secure social Facebook page, where staff could connect.
- Work was being done by the service to engage with the other departments of the hospital, to ensure the developments in critical care services met the needs of the hospital at large and support staff in the rest of the hospital understand the role of the critical care service. This included the critical care outreach team developing links with the general hospital departments and providing training to the general hospital.

## Innovation, improvement and sustainability

- Innovation was supported and encouraged by the service
- An early mobilisation programme initiated by the physiotherapy service on GICU, had won a Health Service Journal Value in Health Care Award. This was now carried out on Neuro ICU and had reduced the

# Critical care

length of stay in the critical care setting and hospital for patients due to the success of this programme. The programme was scheduled to be implemented across the hospital.

- The success of a respiratory education package developed by the education team aimed at the full multidisciplinary team had resulted in it being adopted trust wide.
- Neuro ICU worked closely with manufacturers to support development of service specific equipment. This included working with an overseas company to develop and improve intracranial pressure monitoring equipment and working with the provider of lateral rotating beds for patients with spinal injuries to best meet the needs of patients and reduce risk of injury of staff during complex moving and handling procedures for these patients.
- Neuro ICU, to effectively monitor and compare their outcomes with other similar units, had started to submit data to the Neurological Intensive Care National Audit and Research Centre.
- The development of radiological clot removal for patients with strokes and their subsequent care and treatment in Neuro ICU was improving outcomes for patients who suffered a stroke.
- In Neuro ICU, the purchase of a mobile head CT scanner had reduced the need for patients to be transferred across the hospital, out of hours, for CT head scans. This supported prompt treatment and interventions.
- Effective relations with the hospital's charitable trusts meant the trusts released large amounts of money for critical care service to buy non essential equipment that supported effective practice and outcomes.
- In CICU a consultant was reviewing how to combine clinics so patients did not have to attend the hospital on multiple occasions for clinic appointments.

# End of life care

|                |             |   |
|----------------|-------------|---|
| Safe           | Good        |  |
| Effective      | Good        |  |
| Caring         | Good        |  |
| Responsive     | Good        |  |
| Well-led       | Good        |  |
| <b>Overall</b> | <b>Good</b> |  |

## Information about the service

End of life care at Southampton General Hospital is provided on all wards in the hospital by nursing and medical staff who are supported by the hospital palliative care team. The consultant led team included palliative care clinical nurse specialists and end of life care nurse facilitators.

From January 2016 to December 2016 the total number of adult deaths in the hospital was 1948, approximately 1.5% of admissions. The trust also provides the local hospice service and community services linked to the hospice. This inspection focussed on the provision of end of life care services at Southampton General Hospital.

During the inspection we visited medical, surgical, oncology and critical care wards, the emergency department, the bereavement service, the mortuary and the chapel. We spoke with patients and relatives, 30 staff including service leads, end of life care facilitators, palliative care nurses, medical staff, nursing staff, mortuary staff, porters and chaplains.

We observed interactions between staff and patients, and their relatives. We looked at 14 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms and nine medical and nursing care records. Before and after our inspection, we reviewed service performance information provided by the trust.

## Summary of findings

We rated this service as good because:

- Staff treated patients with dignity and respect. Feedback from patients and their families was consistently positive. Staff paid attention to the needs of relatives and bereaved families; they demonstrated support and compassion in their interactions.
- Patients identified as having end of life care needs were assessed, reviewed and their symptoms managed effectively and recorded in an individualised end of life care plan.
- Medicines were prescribed for end of life patients in anticipation of symptoms to ensure patient comfort. Patient's nutrition and hydration needs were effectively managed.
- We saw positive multidisciplinary working relationships between specialist palliative care team members and ward teams.
- Medical and nursing staff could access the hospital palliative care team for support and advice; the majority of patients were seen within 24 hours of referral.
- Nearly all clinical areas in the hospital had at least one end of life care link nurse to promote best practice in end of life care. The hospital delivered specialist palliative assessments and care in a timely way.

# End of life care

- Patients had access to seven day services with out-of-hours support provided by the local hospice.
- The trust had an interim end of life care strategy based on national guidance and was developing a longer term strategy. The trust steering group on end of life care had executive support and an effective governance structure to lead and monitor service improvements in end of life care. There was staff engagement at all levels to raise the profile of palliative care across the trust.
- The trust's performance in the 'end of life care- dying in hospital' audit 2016 had significantly improved since the previous audit in 2014.

However,

- Learning from end of life care incidents was not spread across all divisions.
- Not all nursing and medical staff had completed safeguarding children level 2 training.
- Not all medical staff had completed mandatory training.
- Not all the DNACPR forms were completed in line with national guidance.
- Not all nursing staff had received formal competency assessment training on use of the syringe driver.
- The trust operated a rapid discharge pathway which served to fast track a dying patient for discharge to their preferred place of care within 24 hours. However, not all patients were able to die in their preferred place of death.
- The trust had not yet audited the views of the bereaved as recommended by the end of life care-dying in hospital audit 2016, although plans were in place to commence this in February 2017.

## Are end of life care services safe?

Good



We rated safe as good because:

- Staff used individualised end of life care plans to assess and record patients' needs.
- Medical and nursing staff had ready access to the hospital palliative care team for support and advice.
- Staff had improved the use of AMBER care bundle approach to manage the care of patients who were at risk of dying in the next few months (AMBER- Assessment, Management, Best practice, Engagement, Recovery uncertain).
- Medicines were prescribed and managed safely for end of life patients.
- Safeguarding vulnerable adults was given priority and staff were able to identify and appropriately respond to safeguarding concerns.
- Medical and nurse staffing levels in the hospital palliative care team had improved since the last inspection and included two end of life care (EOLC) facilitators. The majority of clinical areas had an associated EOLC link nurse.

However,

- Learning from some incidents associated with end of life care was not shared across all divisions.
- The data for the proportion of staff who had undertaken syringe driver competency assessments had not been recorded by the trust, and was not available to inspectors.
- The mandatory training rates for medical staff in the service were below the trust target of 85% in all mandatory training subjects.
- In the palliative care team 51% of nurses and 35% of medical staff had received training in safeguarding children level two. For safeguarding adults, 53% of medical staff, 81% of nurses and 77% of support staff had undertaken the required training.

### Incidents

- Staff we spoke with were familiar with the trust's electronic incident reporting system.

# End of life care

- Data provided by the trust showed staff reported 33 incidents which included a reference to end of life between January 2016 and December 2016.
- There were no never events and one serious incident reported by the palliative care team between November 2015 and October 2016. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, be implemented by all healthcare providers.
- A review of the 33 incidents showed 25 were categorised as having a low impact, seven as moderate impact and one as high impact. Incidents included issues related to 'care implementation and monitoring' and 'medication'. The incident rated as a high impact had been investigated and the root cause identified 'Active treatment (for the patient) continued for too long; palliation was not commenced in timely manner'. Learning was shared from this incident.
- Mortuary staff said they had reported incidents related to issues they had identified when ward staff had not followed the procedures for care of the patient after death. Data showed 54 incidents categorised as last offices were reported in the period January 2016 to December 2016; 52 were graded as very low/low impact and two as moderate impact. The trust informed us these incidents were reviewed thematically and an action plan was developed in October 2016 and updated December 2016. The action plan described the actions taken and progress made to improve compliance with the 'last offices' procedures.
- Our review of notes of operational and team leader meetings there was little evidence of incidents highlighted. For example, there was no mention of incidents relating to the last office procedures in notes of palliative care meetings.
- 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. The trust monitored duty of candour through their online incident reporting system. The consultant clinical lead mentioned e-learning related to duty of candour but had not been involved in any incidents directly.

## Environment and equipment

- The trust had consolidated to one model of syringe pump device, used to administer continuous medicine. A policy and protocol for the use of the device in order to reduce the risk of medicine administration error was in place. Nursing staff we spoke with said nurses who were experienced in setting up the syringe driver would support less experienced staff.
- The trust reported that all nurses were trained on a single type syringe driver during their induction. The training was repeated on the IV updates which all nurses attended on a two yearly basis. The trust had recently implemented a comprehensive equipment training database to log the training. The record of training on IV study days since October 2015 indicated 110 staff had attended training.
- We requested information related to assessment of staff competencies to safely use the syringe drivers. The trust informed us, 'The data for the proportion of staff who have undertaken competency assessments is not available'. We were therefore not assured that all staff had assessed competencies in place to safely use syringe drivers.
- We observed the trolleys used by the porters to convey the deceased patients from the ward to the mortuary were clean and stored in a separate corridor. Deceased patients were conveyed in sealed body bags with appropriate coverings.
- The mortuary was visibly clean. Designated isolation fridges were used for deceased patients with infectious risks.

We observed the palliative care team were 'bare below the elbow' in clinical areas. The staff had access to personal protective equipment and we saw that they used it appropriately.

## Medicines

- Medicines management policies were in-date and included procedures regarding anticipatory medicines. These are medicines prescribed for the key symptoms in the dying phase. For example, to manage pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness.
- Junior doctors we spoke with said they referred to the 'Wessex Green Book – good practice guide for prescribing at end of life' and also sought advice from the palliative care team when needed. We saw there

# End of life care

were clear guidelines for medical staff to follow when prescribing anticipatory medicines for patients. This included how to adjust doses for patients with deteriorating kidney function.

- We reviewed nine medical and nursing case notes of patients identified as being in the last days of life and saw anticipatory medicines were prescribed appropriately. We also saw occasions when the end of life care (EOLC) facilitator had reviewed syringe driver medicines with the doctor as the medicines may impact on the patients poor kidney function.

## Records

- Records systems were a mix of paper and electronic. Staff we spoke with said patients identified as end of life were started on an individualised end of life care (EOLC) plan which was in paper format, except for in critical care where it was available electronically. This was confirmed by our observations during the inspection.
- Staff confirmed they had received training on the introduction of the individualised EOLC plan in 2015/16. They told us the consultant decided when to initiate the EOLC plan and completed the initial assessment and they referred to the palliative care team if needed. We saw evidence of this during the inspection. For example, the EOLC facilitator went through the EOLC plan with a ward nurse to ensure appropriate use of the form to record and evaluate care provided to the patient.
- Staff we spoke with on different wards said the palliative care team supported them with completion of the EOLC plan. Palliative care nurses we spoke with acknowledged that although the EOLC plan had been rolled out, staff use of the plan was variable. A survey to assess staff's understanding of the EOLC plan was underway during the course of the inspection to review ongoing training needs of staff and evaluate completion of the care plan. Following the inspection the trust provided the results of the survey which showed 76% (68/89) nursing and medical staff had used the record. The questionnaire covered medical and nursing staff of different grades and showed a wide variation in confidence and familiarity with use of the record from 'no use' to 'very confident'. The trust planned to use the results to target specific teaching on EOLC documentation.
- Our review of nine records showed variable completion of the EOLC plans, in particular the evaluation of care sections. A ward nurse in charge told us staff reviewed

evaluation of care, but acknowledged they did not consistently document the review of care interventions that took place. For example, we saw two examples on the individual care plan: a box labelled as emotional/spiritual/psychological care had been ticked on most days as being reviewed every four hours with no comments noted as to what input or evaluation had taken place. In another record there was clear evaluation and documentation including spiritual needs met, for example, a note that the patient's own faith minister visited.

- Do not attempt cardiopulmonary resuscitation (DNACPR) forms and the regional forms, in some cases the regional form information was copied onto the hospital form. DNACPR forms were kept at the front of a patient's notes, which allowed easy access in an emergency.

## Safeguarding

- Safeguarding training was mandatory for all trust staff. For palliative care staff safeguarding adults training and safeguarding children training level 2 was required. In the palliative care team 51% of nurses and 35% of medical staff have received training in safeguarding children level two. For safeguarding adults 53% of medical staff, 81% of nurses and 77% of support staff had undertaken the required training.
- The hospital palliative care staff we spoke with were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children. All staff had received appropriate training.
- In our review of records we saw a record of a patient at end of life which showed a safeguarding concern was raised on admission to the ward, in accordance with trust procedures.

## Mandatory training

- The trust's mandatory training programme included moving and handling, infection prevention, fire safety and information governance. Data provided by the trust showed the trust met or achieved the trust target of 85% for the majority of training courses required by nursing staff in the palliative care team except for resuscitation which had the lowest compliance at 68%.

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- Compliance for medical staff was below the trust target for all modules. The subjects that received the lowest training rates were equality awareness (59%), fire safety (38%), health and safety (66%), moving and handling (57%), resuscitation (35%) and infection control (43%).
- On the key indicator for organisational performance in the national end of life care audit – dying in hospital report (2016), the trust answered ‘Yes’ to the question ‘Did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life’ for medical and registered nursing staff.
- Data provided by the trust showed as of January 2017, 75% of consultants involved in cancer services had completed advanced communication skills training and all the staff within the hospital palliative care team had completed training.
- Ward staff told us that end of life care was part of the mandatory training programme and training sessions were available several times a year at the trust hospice.

## Assessing and responding to patient risk

- At the previous inspection in 2014 it was identified staff had not demonstrated a good awareness of the AMBER care bundle approach to manage the care of patients who were at risk of dying in the next few months (AMBER- Assessment, Management, Best practice, Engagement, Recovery uncertain). The trust has now implemented an action which demonstrated improvements in staff awareness of the AMBER care bundle and it was clearly documented in the individualised EOLC assessment section of the plan.
- Staff confirmed the consultant would initiate the end of life care plan and completed the initial assessment. The assessment section included the ceiling of care and escalation plan review. In our review of records, we saw on one occasion the EOLC team had reviewed the plan and advised the EOLC plan be discontinued as the patient was not expected to die in the next few days.
- We observed one patient and reviewed their records on one of the elderly care wards. The patient was due for four hourly mouth care but the record did not indicate four hourly care had been provided. Staff caring for the patient said they had been providing patient’s mouth care more frequently than four hours but had not always documented it accurately.
- The palliative care team aimed to see patients who were already on an individualised EOLC plan at least every two days for review. At the palliative care team daily

- morning whiteboard meeting, we observed patients changing needs were discussed and how to respond. For example, if they were seen by a palliative care nurse or doctor. Patients were prioritised for example, if in uncontrolled pain or had experienced breathing difficulties.
- Ward staff we spoke with were aware of how to escalate changes in a patient’s condition to relevant clinical staff. In such instances, their first step would be to contact the specialist palliative care team for advice and guidance. Ward staff confirmed the end of life care team were very responsive and aimed to attend within 24 hours or sooner if needed.
  - The palliative care team proactively had a handover on Friday afternoons and ensured ward staff had the out of hours contact details along with a clear plan for symptom management.
  - A new triage post had been created in the palliative care team. The nurse in the triage role told us their aim was to offer advice and prioritise referrals based on appropriate information.

## Nursing staffing

- The nurse staffing levels in the hospital palliative care team consisted of one band 8a 0.5 whole time equivalent (WTE) (lead nurse for end of life care), one band 8b 0.5 WTE (matron across hospital and community), four band 7 staff and six band 6 WTE staff, of which two were specifically end of life care facilitators. Since the previous inspection in 2014, the team structure had changed and the establishment had increased. There were no vacancies.
- Data provided by the trust indicated nearly all clinical areas (48 out of 50) had an associated EOLC link nurse. Some areas had more than one link nurse. As of February 2017 there were 67 link nurses of which 52 (78%) were registered nurses band 5 and above.

## Medical staffing

- The Association for Palliative Medicine of Great Britain and Ireland recommendations and the National Council for Palliative Care guidelines state that there should be a minimum of one consultant per 250 beds. Southampton General Hospital had approximately 1100 beds; since the last inspection palliative care consultant cover had

# End of life care

increased from 10 direct clinical care (DCC) [approximately one whole time equivalent (WTE)] sessions to 17 DCC (approximately 1.7 WTE), however this was still below national recommendation.

- The results of the end of life care – dying in hospital report (2016) showed the median specialist palliative care consultant cover in England was 1.08 WTE (for direct clinical care of inpatients) for 1000 adult beds.
- The palliative care consultant lead informed us a business case was in place to increase consultant cover and recruitment was underway for a further palliative care consultant.

## Major incident awareness and training

- The trust's major incident plan (October 2016) applied to all services provided by the trust. The mortuary manager told us they were involved in the plan and participated in major incident exercises and training. They were clear of their role and actions they needed to take in the event of a major incident plan.

## Are end of life care services effective?

Good



We rated effective as good because:

- Patients identified as having end of life care needs were assessed, reviewed and their symptoms managed effectively. We saw positive multidisciplinary working relationships between specialist palliative team members and ward teams.
- The trust's performance in the end of life care- dying in hospital audit 2016 had significantly improved since the previous audit report in 2014.
- Pain relief was prescribed for end of life patients in anticipation of symptoms to ensure patient comfort. Patient's nutrition and hydration needs were effectively managed.
- The majority of clinical areas had at least one end of life care link nurse. Link nurses were supported to develop their role and promote best practice in end of life care.
- Patients had access to seven day services with out-of-hours support provided by the local hospice.
- The percentage of repeat admissions was better than the England average, at 7.2% compared to 17.3% for end of life care.

However

- Not all the DNACPR forms we reviewed were completed in line with national guidance.
- The internal audit completed on DNACPR in March 2016 demonstrated some poor outcomes. For example, 52% of DNACPR decision were discussed with patients and family, and 75% were completed for appropriate reasons. The remaining 25% were completed with inappropriate reasons provided, such as 'asleep', or 'dementia'.

## Evidence-based care and treatment

- End of life care policies and procedures were based on, for example, national guidance such as the National Institute for Health and Care Excellence (NICE) NG31, which defines clinical best practice in care of dying adults in the last days of life. The individualised end of life assessment and planning document took account of the NICE guidance and prompted staff to consider all the domains.
- The trust had implemented training for staff on the end of life care plan in 2015. Staff we spoke with were familiar with the principles of end of life care and were aware of how to use the documentation.
- The trust participated in the national end of life care audit- dying in hospital. The trust performance in the recent audit report (2016) demonstrated significant improvements compared to the previous audit results in 2014.
- Policies and procedures including prescribing protocols for patients at end of life care were in place for staff to follow. This included prescribing protocols, for example, there was a protocol for patients with different degrees of deteriorated kidney function. Medical staff had access to the palliative care handbook, a good practice guide by Wessex Palliative care physicians.
- The service undertook six local audits in addition to their national audits. The audits being completed at the time of our inspection included, 'Discussions about artificial hydration at the end of life at CMH', 'Diabetes management', and 'Management plans for tracheostomies at end of life'.

## Pain relief

# End of life care

- We saw the trust's medicines policies included prescribing of anticipatory medicines for end of life care. The anticipatory medicines guidance was under review and due to be finalised shortly.
- The hospital palliative care team told us that pain management was a major part of their work on the wards.
- Medical staff we spoke with said they valued the advice from the palliative care team regarding management of patients' pain control and gave examples of when they had referred to the team. Staff also referred to the palliative care handbook which contained information on pain control and opiate conversion doses.
- The individualised EOLC plan included a review of pain and pain flow chart. Our review of records showed input from the palliative care team on prescribing of medicines for pain management and combination of drugs for use in the syringe driver. We also saw anticipatory medications were prescribed for patients at end of life.
- The trust reported they were partly compliant with the Core Standards of Pain Management (2015) although an audit had not been carried out. In 2015/16, the palliative care team assessed pain and gave advice on pain management on 6553 occasions.

## Nutrition and hydration

- The end of life care "dying in hospital" report (2016) showed the trust performed worse than the England average for the indicator: was there a documented assessment of the patient's ability to drink in the last 24 hrs of life? 60% compared to 67%. However, the trust performed better on the indicator: Was there evidence that the patient was supported to drink in the last 24 hours of life?; 47% against 45%.
- Staff used a screening tool, the malnutrition universal screening tool (MUST) to identify those patients who were nutritionally at risk. When patients were identified as at risk, fluid and food charts were put in place and referral made to a dietitian if necessary.
- Staff were aware of the GMC guidance on nutrition and hydration. Link nurses confirmed that care plans identified what patients could eat, and the plans were regularly updated.
- We saw in records palliative care team documented their input and advice, for example, we saw one entry

where palliative care team advised to give a patient fluids every two to three hours to prevent thirst, however, this advice was not taken and no explanation documented.

## Patient outcomes

- The trust's performance in the end of life care- dying in hospital report (2016) had significantly improved since the previous audit in 2014. The trust performed better than the England average for four of the five clinical indicators. It performed slightly worse on the indicator: Is there documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days, the trust scored 81% compared to the England average of 83%.
- The trust performed significantly better on the indicator 'Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care?' 76% compared to 66%.
- On the key indicators for organisational performance, the trust answered 'Yes' to five of the eight organisational indicators. The trust answered 'No' to did they seek bereaved relatives or friends' views during the last two financial years and 'did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life' for non-registered nursing, and allied health professional staff.
- The service provided data to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on an annual basis to provide a picture of specialist palliative care service activity across the country. It allows units to compare their activity within the region and nationally. We reviewed the inpatient data set which showed the percentage of repeat admissions was better than the England average, at 7.2% compared to 17.3%.

## Competent staff

- Two of the clinical nurse specialists in the palliative care team were end of life care facilitators; they rotated between the specialist hospital palliative care team and EOLC role.
- All clinical staff received training on end of life care. Ward staff told us they had received training on the

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individualised EOLC plan for the last days of life by the palliative care team and on use of the syringe driver. The trust had appointed a palliative care education and training lead nurse to support staff.

- Ward staff were supported by the palliative care team, informally and through ward based training on, for example, symptom control. The band 5 competency framework for nurses included end of life care training.
- The trust reported consultants in a number of divisions had received end of life care training at care group meetings or mortality and morbidity meetings. However no training data was available to support what we were told.
- Following the introduction of the individualised end of life care plan for the final hours or days of life, the palliative care team carried out training for ward based clinical staff, consultants and specialist doctors were included in this.
- Medical staff received training on end of life care and the palliative care handbook, a good practice guide by Wessex Palliative care physicians, as part of their induction programme.
- Staff in the palliative care team received regular annual appraisals. The trust target was 92%. As of January 2017, trust data showed 85% of non-medical staff had participated in an appraisal.

## Multidisciplinary working

- During the daily whiteboard meeting held by the palliative care team, we observed effective communication, respect between participants and exchange of information, request for assistance between nurses and doctors and discussions to maintain continuity of care if patients were known to a particular staff member. Staff demonstrated an up to date knowledge of area of expertise.
- The hospital palliative care team multidisciplinary meeting was held once a week. The team reviewed all cases of palliative care including the appropriateness of medicines and achievement of preferred place of care. Patients who were discharged or died were also discussed including ongoing support to their families, when appropriate.
- Medical staff we spoke with described an excellent service from the palliative care team.
- Therapy staff: physiotherapy and occupational therapy staff said they had a good working relationship with the palliative care team. For example, physiotherapy staff

told us they were sometimes involved in supporting patients with chest conditions at end of life. We saw evidence of input from speech and language therapist in a patient's notes to assess a patient's swallow.

- Ward staff were positive about the support they received from the palliative care team and said there was always someone to ask for advice.
- We spoke with a consultant in intensive care who said they worked well with palliative care team; they told us "They (the palliative care team) are invaluable in supporting patients in transfer to wards" and welcomed the initiative of the joint weekly critical care palliative care ward round.
- The hospital managed the local hospice which facilitated close links and strong working relationships. Similarly there was close working arrangements with the community palliative care team, facilitated by a matron whose role covered both hospital and community palliative care services.

## Seven-day services

- The University Hospitals Southampton hospital palliative care service was available daily 8.30am to 4.40pm including weekends. An on call service was provided out of hours. They prioritised those patients expected to die in the next 24 hours.
- The hospital had established links with the local hospice and community palliative care team and could access any specialist advice from clinical staff and from a palliative medicine consultant 24 hours a day. Staff confirmed that they could access advice and support from the team at any time.
- Our observation of the palliative care handover meeting showed staff were knowledgeable and discussed treatment options for patients.
- The mortuary service was available 8.30am to 5pm, Monday to Friday and 10am to 2pm, Saturday, Sunday and bank holidays. Outside the core hours, mortuary staff operated an on call service.
- Chaplaincy support was available 24 hours every day, in person during office hours and on call out of hours.
- The bereavement service was available 9am to 4.30pm Monday to Friday.

## Access to information

- Staff had access to hospital policies and specific guidance on end of life on the trust intranet.

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- The individualised end of life care plan was available in paper and electronic format in different clinical areas. We observed staff accessed patients' records on the electronic patient record to check on the latest entries during the daily handover meeting.
- Staff in the hospital, hospice and community palliative care teams were able to access the same patient electronic system and this facilitated information transfer and access to information within the multidisciplinary team.
- Bereavement care staff were able to view the electronic system used by porters. This enabled them to be aware of which patients had died in the hospital and which ward.

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

- Staff we spoke with said band 7 nurses and doctors were responsible for doing capacity assessments. Nurses could describe when they would refer somebody for a capacity assessment. However, staff understanding was variable. For example, some staff did not have a clear understanding of MCA and decision specific assessment for day to day care.
- Data provided by the trust showed that as of March 2017 MCA training had been completed by 75% of staff within end of life care.
- We reviewed 14 'do not attempt cardiopulmonary resuscitation (DNACPR) forms during the inspection. We found 10 out of 14 forms we reviewed were fully completed; the ones that were not fully complete were because different sections were not complete such as lack of capacity assessment. In the majority of records we saw clearly documented discussions with the patient's relatives and the patient's wishes had been taken into account and MCA checked before completion of the DNACPR.
- In our review of surgical records we found some patients who had do not attempt resuscitate decisions agreed had very poor documentation of the decision in their notes. There was one out of the four seen that had been updated when the patient's condition improved.
- The trust carried out an annual DNACPR audit. The results of the audit for the period April 2015 to March 2016 showed for the standard: there is evidence of discussion with the patient or relative, the trust achieved 52% (1019). An action plan was devised in

response, which included a further audit specifically to review where the DNACPR audit form recorded that there was no discussion with the patient. This audit showed 75% (169) DNACPR forms recorded justifiable reasons why the DNACPR decision could not be discussed with the patient. Examples included patient being unconscious, having dementia, palliative care and severe head injury, where best interest assessments were undertaken.

- The action plan (December 2016) showed actions relating to improved recording in patients' medical notes the reasons DNACPR decisions were not communicated to patients. This was recorded as embedded in practice in January 2017.

## Are end of life care services caring?

Good



We rated caring as good because:

- Compassionate and person centred end of life care was provided to patients on the wards by medical and nursing staff and the specialist palliative care team. Medical and nursing staff showed sensitivity when communicating with patients and relatives
- The specialist palliative care team spoke with care and compassion at their handover meetings and considered the dignity of end of life patients. They were sensitive to patients' needs in a holistic way.
- Feedback from patients and their relatives was consistently positive about the care they had received. Relatives were supported to visit or stay at the hospital.
- All staff we spoke with valued and respected the needs of both, the patients and their families. Patients' emotional, social and religious needs were considered and were reflected in how their care was delivered.
- The bereavement and mortuary staff were caring, understanding and responded sympathetically to patients and relative's needs.

However,

- The trust did not carry out a bereavement survey, although plans were in place to commence this in February 2017.

## Compassionate care

# End of life care

- We spoke with a small number of patients and relatives. The feedback we received was all positive. Relatives described examples of compassionate and sensitive care. They made comments such as “Staff are doing everything for us.”
- We observed where possible patients were cared for in side rooms to allow an enhanced degree of privacy and dignity for them and their families.
- The trust allowed open access visiting to relatives of end of life patients. Relatives said the ward staff made them feel welcome at all times.
- We spoke with portering staff who were responsible for conveying the deceased body to the mortuary. Portering staff demonstrated an attitude of respect and compassion for patients and their relatives. They took care to ensure a discreet route where possible from the ward to the mortuary and used the service lift to make the transfer as private and dignified as possible.
- Staff said often they tried to place a person at the end of their life in a side room. However, if the patient or a deceased patient was in a bay, all privacy curtains were drawn and staff were respectful in their approach.
- Portering staff said they had not experienced any issues conveying patients to the mortuary. When relatives of the deceased wanted to accompany the patient to the mortuary this was arranged and normally a nurse would also be an escort.
- Mortuary staff were knowledgeable and demonstrated a deep respect about caring for deceased patients and relatives of different faiths.
- Bereavement care staff we spoke with displayed a family centred and sensitive attitude. At a bereavement support meeting, relatives were given the belongings of the deceased in a suitable bag for this purpose. At this meeting, relatives were given the opportunity to meet with clinical staff to discuss any concerns they had about the care of their relative at end of life.
- During the inspection, we observed that staff were compassionate and caring and treated patients with dignity and respect. All the staff we spoke with were clear about their role in ensuring that people received appropriate support. Where we raised concerns, for example a patient who staff said had been lying staring at the ceiling for a long period of time with no obvious stimulation, action was taken.
- The trust achievement in the end of life care- dying in hospital audit (2016) was much better than the England average for the indicator: Is there documented evidence that the needs of the person(s) important to the patient were asked about? 63% compared to 56%
- In our observation of the palliative care staff meeting staff demonstrated a good knowledge of patients’ wishes and holistic care of family and how to meet their needs.
- There was an information leaflet for relatives of patients receiving end of life care which covered support and facilities for relatives.
- Staff would offer relatives the opportunity to care for their relative, showing them, for example, how to carry out mouth care on the patient, if they wished
- In our review of notes we saw examples of regular documented discussions with patients’ relatives since the patient had been admitted. We saw a well-documented discussion with family around end of life care and return to a nursing home. In another set of notes we saw documented discussions with a family and patient about the risks and benefits of travelling abroad.
- The individualised care plan for the last days of life included a tear out sheet that explained to the patient’s next of kin what to expect when someone dies.
- Staff could give examples of how they would support families with the transition from receiving treatment to going onto the end of life care pathway.

## Emotional support

- Ward staff, chaplains and trained volunteers and psychologists provided support to patients and relatives. we spoke with described a good relationship with bereavement office
- Our observations of the palliative care team handover meeting showed their consideration of patient’s wishes and where they wanted to die and family involvement in the patient’s care.
- Staff talked about psychological support for patients in the multidisciplinary meeting.
- Nurses told us that doctors included them when breaking bad news to families so the nurses could explain and reassure relatives if they had any questions after the doctor had left.
- Bereavement counsellors described how they would offer extra sessions to families who needed support and

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

# End of life care

refer to bereavement counselling where appropriate. Bereavement counsellors supported families to understand the grieving process and allow themselves time to grieve.

- We spoke with the chaplain who told us the chaplain service had access to volunteers and chaplains of other faiths including humanist. An honorary faith representative was linked to clinical areas. Chaplaincy volunteers supported patients by visiting and transporting them from wards to Sunday service in the hospital chapel.
- The end of life care – dying in hospital audit (2016) indicated the trust did not ‘seek bereaved relatives’ or friends’ views during the last two financial years’. In response the trust was planning to conduct a survey of bereaved families throughout February 2017 in order to gather feedback about the service.

## Are end of life care services responsive?

Good



We rated responsive as good because:

- People’s needs were met through the way end of life care was organised and delivered.
- The hospital delivered specialist palliative assessments and care in a timely way. Patients were reviewed by the specialist palliative care team within 24 hours of a referral. A new triage post had been introduced in the palliative care team to provide advice, facilitate appropriate referrals and prioritise end of life care referrals.
- There was open access for relatives visiting patients who were dying. There was accommodation available for families who wished to stay overnight.
- There were adequate facilities to meet individual’s spiritual and cultural needs through the chaplaincy service and practical support via the bereavement service.
- The trust operated a rapid discharge pathway which served to fast track a dying patient for discharge to their preferred place of care within 24 hours. Between July 2016 and December 2016 data showed that out of 226

patients on fast track discharge, 60% were successfully discharged and 40% (91) died before being discharged. The trust said they were working with partners to improve this position.

- The trust had not received any complaints relating to end of life care and was exploring ways of improving identification of complaints which may have been linked to end of life care provision to improve the service.

However,

- There were delays in discharging patients home to die and patients were not always able to die in their preferred place of death. The trust were working to improve the situation.
- Between June 2016 and December 2016 out of 1003 patients who died 36% died in their preferred place of death and, 9% did not, the remainder was recorded as ‘not known.’

## Service planning and delivery to meet the needs of local people

- Four specialist palliative care beds were commissioned and provided on the oncology ward. The trust reported they had 31 inpatient palliative care beds, four in the cancer care wards at Southampton General Hospital and 27 in the hospice. As a regional centre for many services the hospital accessed other hospices and said they had good relationships with them. The trust was in discussion with the CCGs to develop the provision of palliative care services to cover 24 hours seven days a week and an integrated hospice at home service.
- Patients who required end of life care were cared for on general medical and surgical wards.
- Nursing staff we spoke with on the wards told us they would give priority to the care of those patients in the last days of life and would try to offer a side room to allow privacy and dignity for the patient and family.
- A room was available for relatives who wanted to stay overnight at the hospital. Relatives told us that they were able to visit the ward at any time when their relatives were approaching the end of life.
- Patients could be discharged to the local hospice run by the trust. Nurses told us there were strong links with the local hospice as the consultants worked for both the hospital and the hospice.
- The hospital palliative care team provided specialist advice, support, training and education in palliative care

# End of life care

across the trust. In addition, the end of life care team supported staff on the wards to provide care for patients who were at the end of their lives. Individual wards had end of life link nurses who acted as champions for end of life care on the wards.

- End of life care patients were generally offered a side room unless these were being used to nurse an infection-control patient. In such instances, the end of life care patients were nursed in the bays.
- There was a viewing room attached to the mortuary and a smaller viewing room was available in the emergency department. Both rooms were appropriately decorated and fitted for relatives to be with the deceased.
- A nurse triage post had commenced as a pilot project to review all hospital referrals for the palliative care team. We spoke with the triage nurse who explained they were able to advise referrers and ensure appropriate referrals were made and prioritised. For example, end of life urgent referrals for patients actively dying were prioritised.

## Meeting people's individual needs

- Staff we spoke with described how they cared for patients with dementia at end of life, for example, making sure they were not left alone and putting a light over their bed so they were "not disturbed by people or shadows." Ward staff could ask for advice and support or refer patients to the enhanced care support team for patients with learning disabilities or dementia. Another nurse gave an example of caring for a relative with dementia whose partner was at end of life. Nursing staff made sure the relative was not left alone and would offer them meals during their visits.
- We spoke with health care assistants and registered nurses who had the role of end of life link nurse. They were all passionate about their role and confirmed they had support from other link nurses through quarterly meetings. They also attended an annual trust wide end of life care conference in 2016. Link nurses had the opportunity to attend training on 'breaking bad news and counselling'.
- Data provided by the trust indicated nearly all clinical areas (48 out of 50) had a link nurse. Some areas had more than one link nurse. As of February 2017 there were 67 link nurses of which 52 (78%) were registered nurses band 5 and above.

- The link nurses attended a quarterly full day meeting led by the palliative care education and training lead nurse. The role of the link nurse was reviewed in December 2016. The purpose of the link nurse role was to promote best practice in end of life, palliative, spiritual and bereavement care. They were supported through quarterly information and development days, which were led by the training and education lead palliative and end of life care nurse.
- The hospital had a large multi-faith room with a small Christian chapel and a Muslim prayer room.
- Surgery ward manager told us they had no problems accessing chaplaincy support for end of life patients.
- Ward staff would check whether family wanted to visit the deceased on the ward before the body was transferred to the mortuary.
- The trust employed six Christian chaplains: Church of England, Roman Catholic and Methodist. Honorary faith representatives were available to cover all faiths. The chaplains provided spiritual and religious support to patients and staff. The chaplain office had access to chaplains of other faiths and called upon them when needed.
- The bereavement service supported families in a number of ways including obtaining the death certificate, organising viewing appointments and support with funeral arrangement. Some bereavement staff were also trained counsellors and could provide grief counselling.
- Relatives visiting the bereavement care office had access to three parking spaces available free of charge. The wards arranged discounted parking tickets for relatives visiting end of life patients.
- Patients' wishes relating to organ donation were recorded in patients' notes. The bereavement service managed organ donation liaising with relatives to ensure they were fully informed.
- The bereavement leaflet was readily available in English and staff could obtain the leaflet in other languages and Braille if necessary. Staff could access hospital translation services if needed.
- Mortuary staff we spoke with described an effective relationship with local faith leaders. This included 24 hours access via an on call service to the local mosque and synagogue.
- The trust's achievement for the end of life care – dying in hospital audit (March 2016) for the two questions: Is

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there documented evidence of care of the patient immediately prior to or at the time of death? And care of the patient immediately after death? Showed the trust was worse than the England average at 67% against 73% and 56% against 63% respectively.

## Access and flow

- The trust bed occupancy figures between April 2016 to December 2016 were slightly higher than the England average; 93% compared to 90%. Research suggests bed occupancy rates above 85% can impact on the patient flow through a hospital and infection rates.
- Between January 2016 and December 2016, the trust recorded 1948 inpatient deaths this figure represented approximately 1.5% of hospital admissions.
- The number of patients dying in hospital had increased by approximately 5% each year for the last three years. Data provided by the trust showed the number of referrals to the palliative care team increased year on year since 2012/13, For example, between April 2016 and December 2016, the number of referrals were 1650 patients and this represented an increase of approximately 5% compared to the previous year.
- Approximately 87% of patients were seen within 24 hours of referral and 3.5% (65) patients died before being seen.
- The team received referrals which were broadly divided into one third of cancer patients, one third of patients who had cancer but not the primary diagnoses and one third from patients who did not have a diagnoses of cancer. In the six months, between June 2016 and December 2016 out of 1003 patients who died 36% died in their preferred place of death and, 9% did not, the remainder was not known/ not filled.
- Data on the latest audit of rapid discharge (July 2016 to December 2016) showed that out of 226 patients on fast track discharge, 40% (91) died before being discharged. The trust said they were working with partners to improve this position.
- Since the previous inspection the trust now had four specialist palliative care beds on the oncology ward. The palliative care beds were prioritised for symptom control and de-escalation of care from critical care.
- The palliative care team said rapid discharge of patients into Southampton city was “easier” to facilitate than into

other areas due to the number of hospice beds available. The trust had a target of four hours for rapid discharge referrals. Ward staff were positive about the support they received to make rapid referrals.

- We spoke with the consultant in intensive care who said they worked well with the palliative care team and they were invaluable in supporting patients in transfer to the wards/home or hospice.
- The trust reported they did not collate data on bed moves for patients at end of life and would not move a patient unless it was to a single room, hospice bed or had been requested by the patient or relative.

## Learning from complaints and concerns

- The clinical lead told us there had been no complaints directly relating to the palliative care team in the last 12 months. However, the lead palliative care nurse was working with the complaints team to analyse the coding so that any issues which related to end of life were also referred to the palliative care team.
- The bereavement service staff supported relatives to informally resolve any concerns they had about the quality of care and would inform people of how to make a formal complaint.
- The bereavement support staff gave an example of how they would feedback to the ward if a relative had been impacted by poor communication.
- We saw thank you letters to the palliative care team from relatives of patients who had died, expressing their gratitude for kindness and compassion shown by staff.

## Are end of life care services well-led?

Good



We rated well led as good because:

- There was evidence of visible leadership of palliative care services and meaningful staff engagement at all levels with regards to end of life care. There was executive support for the palliative care team and across all divisions to raise the profile of palliative care.
- Staff demonstrated values which promoted good end of life care and provided a service to support patients and relatives.

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- The trust had an interim end of life care strategy based on national guidance and was developing a longer term strategy.
- There were effective governance arrangements to monitor quality from team level to the trust board. The quality, risks and performance issues within end of life care were monitored through the executive governance framework.

However,

- The trust had not audited the views of the bereaved as recommended by the end of life care-dying in hospital audit 2016.

## Leadership of service

- The service was led by a consultant and a matron. Palliative care was in the care group of cancer care in division A.
- The consultant lead demonstrated effective leadership and had worked across the trust to improve the care of patients at end of life. The palliative care team leadership consisted of the palliative medicine lead consultant, lead nurse in palliative care and matron for end of life care and end of life care educator.
- The end of life care steering group was chaired by the trust director of nursing, who was the trust lead for end of life care. The group reported to the trust executive committee.
- A non-executive director was appointed as end of life care lead and was a member of the EOLC steering group.
- Through our discussions with staff we found the palliative care team were highly regarded throughout the hospital. Medical and nursing of all levels we spoke with told us they had found the palliative care team to be responsive and accessible.

## Vision and strategy for this service

- The trust worked in collaboration with the local clinical commissioning group (CCG) to produce an interim end of life care strategy (September 2015 to March 2017) which outlined the trust's aims and objectives of the trust in providing patients with a 'peaceful and dignified death within their chosen environment'. A longer term three to five year strategy was under development

informed by the latest national guidance issued by NICE and the End of Life Care Ambitions Partnership as well as the results national End of Life Care Audit: Dying in Hospital (2016).

- The palliative care team had undergone a reorganisation since the previous inspection. The lead consultant told us they had considered different models of provision but had opted for an integrated end of life care team with the palliative care service. Palliative care team staff were clear of the aims of the service and were involved in implementation of aspects of the strategy through membership of work stream groups.
- The leadership of the palliative care service felt the trust leadership had a good awareness of end of life care and saw it as a priority for the trust.

## Governance, risk management and quality measurement

- The palliative care service was part of division A in the cancer care group of the trust. The palliative and end of life operational group was chaired by the head of patient safety and had representatives from all divisions.
- The trusts divisional structure was utilised for reporting quality governance: Care Group governance reports were reported into the divisional governance, which reported to the trust quality governance steering group (QGSG) and ultimately to the trust board. Other specialist sub groups also reported directly to the QGSG, for example end of life care steering group.
- There were audit and review systems to monitor the quality of the service, for example, the Do not attempt cardiopulmonary resuscitation (DNACPR) audits and an internal quality review on end of life care carried out in June 2016.
- We reviewed the action plan following the internal quality review in June 2016. It contained 19 actions across six areas including medication and safety, education, individualised end of life care plan, transition from active treatment to palliative treatment, environment and transitions in and out of Southampton General Hospital. Every action was RAG risk rated and included progress and planned review/completion date for each action. Although, there were no actions relating to the care of the patient after death and involvement of the mortuary staff.

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- The integrated medical examiners group (IMEG) reviewed all deaths and approved the death certificate before it was signed, including contact with the coroner if needed. Meetings took place twice a day and the palliative educator attended meetings twice a week.
- The cancer care group had a risk register which was reviewed at governance meetings. There were no risks relating to the hospital palliative care service.
- Quarterly link nurse meetings were held to share learning and provide support for staff to develop their role.
- The hospital palliative care team had regular team meetings in which the team discussed patient care and the service performance in meeting certain key performance indicators. These meetings were held once a week and were well attended by the team.

## Culture within the service

- Staff felt there was a 'can do' culture striving for excellence.
- Staff we spoke with demonstrated the trust values of: 'Putting patients first, working together and always improving.' We observed mutual respect and professionalism between professional groups.
- Staff we spoke with in the palliative care team displayed a strong team working ethos to meet patients' needs in a holistic manner.
- Consultants gave examples of how relationships had improved with certain departments which demonstrated a culture of improvement and openness.

## Public engagement

- The end of life care – dying in hospital audit (2016) indicated the trust did not 'seek bereaved relatives' or friends' views during the last two financial years'. In response the trust was planning to conduct a survey of bereaved families throughout February 2017 in order to gather feedback about the service.
- An information sheet for relatives was included in the individualised end of life care plan and a survey form in the bereavement leaflet to encourage relatives to submit their feedback.
- The end of life care operational group met every two months and included a trust board governor member.
- Although there was little feedback from relatives about the service, the trust invited bereaved relatives to meet

with the Chief Executive over lunch to hear about their experiences. The last 'listening lunch' with bereaved relatives was held in September 2014 and this was due to be repeated on a three yearly cycle.

## Staff engagement

- Staff we spoke with were highly-motivated, and although the hospital was large there was a friendly atmosphere and staff told us they were happy at work.
- Bereavement support was offered to staff and additional team support if staff were involved in particularly difficult cases, for example, in critical care.
- Palliative care staff described, "Excellent links" with the hospice and community palliative care service to share learning and skills.
- Mortuary staff felt less engaged with the trust, but actions had been taken to improve this. For example, a meeting had been arranged with the care group director.

## Innovation, improvement and sustainability

- The trust participated in the patient and family centred care, living well to the very end programme.
- The trust initiated a project to improve end of life care for patients and their relatives in the department for medicine for older people, improvements included refurbishment of the relatives' room, introduction of an e-prescribing bundle for end of life medicines and breaking bad news communication skills.
- The service had initiated weekly joint ward rounds in critical care, palliative critical care ward rounds.
- The introduction of the rapid access multidisciplinary palliative assessment and radiotherapy treatment (RAMPART) clinic was a 'one stop' clinic for cancer-induced bone pain and combined palliative care and clinical oncology assessment with planning and delivery of one fraction palliative radiotherapy in a single hospital visit.
- The mortuary commissioned the design of a new specification and type of viewing bier (trolley) to be used in the viewing area or if required within ward areas without causing unnecessary distress. The unit allowed height adjustment for wheel chair users and was safe for bariatric patients.

# Outpatients and diagnostic imaging

|                |                                 |   |
|----------------|---------------------------------|---|
| Safe           | Good                            |  |
| Effective      | Not sufficient evidence to rate |  |
| Caring         | Good                            |  |
| Responsive     | Good                            |  |
| Well-led       | Good                            |  |
| <b>Overall</b> | <b>Good</b>                     |  |

## Information about the service

The University Hospital Southampton NHS Foundation Trust provides outpatient appointments and diagnostic imaging services for a wide range of medical, surgical and ophthalmology specialities. The trust provides outpatient and diagnostic services at Southampton General Hospital and the Royal South Hants Hospital, the latter providing ear, nose and throat (ENT), trauma, orthopaedic and dermatology specialties. The trust is also a regional cancer centre.

Outpatient appointments are available Monday to Friday, between 9am and 5pm, with some clinics held in the evenings and Saturday mornings to reduce waiting times. The trust had 616,712 first and follow-up outpatient appointments between April 2015 and March 2016.

Diagnostic imaging services are provided on both sites. They offer magnetic resonance imaging (MRI), computerised tomography (CT) scanning, ultrasound and x-rays. Other diagnostic services provided by the trust include echocardiogram (ECG) and phlebotomy. The service was available 24 hours a day for emergency radiology.

Patients can make outpatients appointments with the patient service centre, open 8am until 8pm Monday to Friday and on Saturday mornings.

During our inspection, we visited the main outpatients' areas and diagnostic imaging at University Hospital Southampton and at Royal South Hants Hospital. We

observed and spoke with patients and staff working in the following clinical specialities: ophthalmology, cardiology, gynaecology, physiotherapy, diagnostic imaging, medicine, respiratory, urology and orthopaedics.

We spoke with 10 patients and six relatives. We spoke with approximately 59 staff including nurses, healthcare assistants, medical staff, physiotherapists, radiographers, administrators, reception staff, medical secretaries, and divisional managers. We observed care being provided, reviewed patient records and analysed data provided by the trust both before and after the inspection.

# Outpatients and diagnostic imaging

## Summary of findings

We rated this service as good because:

- There were appropriate processes in place for reporting incidents and staff confirmed they received feedback and shared learning within their departments. In diagnostic imaging, staff were confident in reporting ionising radiation (medical exposure) IR(ME)R incidents.
- Staff had a good understanding of duty of candour and what their roles and responsibilities were in relation to applying it to their everyday practice.
- The outpatients and diagnostic departments were well organised and visibly clean, and there was no shortage of necessary equipment.
- Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. There were local audit programmes in place to monitor clinical standards.
- Staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was consistently positive. We saw good examples of staff providing care that maintained respect and dignity for the individual.
- National waiting times were met for outpatient appointments, cancer referrals, treatment, and diagnostic imaging. Work had been completed in a number of specialities, including ophthalmology, to help achieve the referral to treatment time targets. The trust offered a number of one-stop clinics to reduce patient visits.
- Governance processes monitored risk and quality performance and were well developed within the outpatient and diagnostic imaging departments.
- Nurses and radiographers spoke highly of their immediate line managers. They told us they felt well supported and valued. Staff told us that they enjoyed working for the trust due to the strong team support from the Chief Executive and Director of Nursing.

However:

- Within outpatients, learning was shared within specialties, but not always across the trust as a whole.

- Patient records were not always stored secured safely breaching patient confidentiality.
- The management of prescription pads and patient group directions in outpatients was not in line with national guidance.
- Staff had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards but had limited exposure to patients requiring mental capacity assessments. Most staff we spoke with were unclear the actions they would take if they had concerns about a patient's capacity to understand information and consent to treatment.
- Although staff were aware of their safeguarding responsibilities, most staff did not have a clear understanding of the process.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



We rated safe as requires improvement because:

- Outpatient and diagnostic imaging staff understood how to report incidents and these were investigated. Within outpatients, learning was shared within specialities but not across the trust as a whole.
- In diagnostic imaging, staff were confident in reporting ionising radiation (medical exposure) IR(ME)R incidents. They followed correct procedures to report these incidents to the radiation protection team and the Care Quality Commission.
- Equipment in use was well maintained and had been regularly serviced. The resuscitation trolleys were checked daily, and staff followed procedures to ensure that all equipment was in date.
- Patients' records were available for all appointments and were found to be thorough and legible. Information was shared with GPs to enable continuity of care.
- Staff had a good understanding of duty of candour and what their roles and responsibilities were in relation to applying it to their everyday practice.

However:

- Most staff had completed adults and children safeguarding training. However, staff were not always confident about what would be considered a safeguarding concern and who to report a concern to.
- The management of prescription pads in outpatients did not comply with national guidance, increasing the risk for loss of, or inappropriate use of, prescriptions. Patient group directions (PGD) allow trained non-prescribers to administer medicines without prescription. The PGDs were mostly in date, with the exception of dermatology where draft copies were used.
- Patients' records were not always stored securely, creating potential risks to patient confidentiality, care and treatment.

### Incidents

- In outpatient clinics and diagnostic imaging services, incidents were reported on the trust electronic reporting system. Staff felt confident with the process for reporting

incidents and confirmed that feedback was disseminated during team meetings, to share learning and improve patient outcomes. For example, the radiology lead sent out emails on "lesson learnt" which gave an outline of the incident and any key learning points.

- Radiography staff told us that there was an open reporting culture and that their line managers encouraged staff to report incidents where applicable.
- Within outpatients, learning was shared within specialities, but not always across the trust as a whole.
- From January to December 2016, there were 809 incidents reported relating to outpatients and diagnostics.
- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. From November 2015 to October 2016, the trust reported no incidents that were classified as never events for outpatients.
- From November 2015 to October 2016, the trust reported one serious incident in outpatients, which met the reporting criteria set by NHS England.
- In diagnostic imaging, ionising radiation (medical exposure) incidents were reported to the trust's radiation protection team and to the Care Quality Commission under IR(ME)R guidelines.
- The radiation protection adviser (RPA) report for December 2016 showed 24 incidents (relating to ionising and non-ionising radiation) had been reported within the last year.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support. Staff gave examples of when they had applied duty of candour and learning because of an incident. For example, a patient had the wrong hip x-rayed, it was discussed with the patient and a "being open form" was completed.

# Outpatients and diagnostic imaging

## Cleanliness, infection control and hygiene

- All outpatient clinics and diagnostic imaging areas we visited were visibly clean and tidy. We observed staff following good infection control practices, such as cleaning their hands before and after patient contact and ensuring they were 'bare below the elbow', minimising the risk and spread of infection to patients. However, at Royal South Hants hospital we found a hand wash sink visibly dirty and curtains dusty and torn. An external company maintained the curtains and cleaning. Staff were unable to provide a cleaning schedule or dates of when the curtains were last changed.
- In all clinical areas, there was good evidence of personal protective equipment (PPE), such as gloves and aprons being available and used appropriately by staff.
- Data provided by the trust from May to November 2016 showed three monthly hand hygiene audits had been completed in all outpatient and diagnostic imaging areas. Compliance ranged from 86% to 100%. The trust had a target of 85%.
- Handwashing facilities were available in all clinical areas and hand gels were provided for staff and patients in all communal and clinical areas.
- All consulting rooms had sharps bins available for the safe disposal of needles. We observed sharps bins had been correctly signed on assembly and staff ensured these were not overfilled in line with best practice for health and safety.
- At both hospitals, cleaning schedules were in use in outpatient clinic rooms, which showed staff what should be cleaned, and with what cleaning material. The cleaning schedules we checked were complete and up-to-date.
- There were arrangements in place to protect patients from the risk of acquiring a healthcare associated infection. Staff in outpatients and diagnostic imaging told us if a patient was known to have an infectious disease, they would try to see them at the end of the day. The area and any equipment would be thoroughly cleaned to minimise the infection risk to staff and patients.
- Members of the physiotherapy team checked temperature, pH and chlorine levels of the water in the hydrotherapy pool three times a day. We saw records in the physiotherapy department confirming this practice.

- In diagnostic imaging, we saw staff completed cleaning schedules. Radiographers took responsibility for cleaning equipment after each use. Equipment used for invasive procedures was decontaminated in a suitable way.
- In March 2017, 94% to 96% of staff in diagnostics and 100% of staff in outpatients completed mandatory infection control training. The trust target was 85%.

## Environment and equipment

- The ladies changing cubicles in the physiotherapy department did not have doors, they could be accessed by the corridor or via the waiting area. Staff also stored their personal items in lockers within the changing room and we found some of these open.
- The resuscitation trolleys in outpatients and diagnostic imaging were checked daily and all the equipment was found to be in date. In the hydrotherapy unit, a stretcher was available to transfer patients out of the pool area in an emergency. Staff also had access to a technician and engineer should any maintenance issues arise.
- Staff followed the trust's policy for the disposal of clinical waste. The sharps audit in April 2016 showed the radiology department achieved 96% to 100% compliance, against the trust target 85%.
- In diagnostic imaging, there was signage to alert patients to potential radiation hazards in relevant areas. Radiography staff told us and we saw signed documentation to confirm staff had read local rules and adhered to these.
- Personal protective equipment such as lead aprons were always available for staff to use. Lead protection coats were regularly screened with x-rays to check for any defaults and up to date screening records were seen. On the day of the visit, the lead coats we visually inspected were in good order and clean.
- The portable appliance testing on all items we looked at were in date, and the equipment appeared to be in good condition.

## Medicines

- In the departments we visited, medicines were stored safely and securely and all items we checked were in date. Radiology contrast media were stored in a locked drugs cupboard, in a locked clean store room.
- Patient group directions (PGDs) were used in two outpatient departments. A PGD direction allows some registered health professionals (such as nurses) to give

# Outpatients and diagnostic imaging

specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. A PGD is used in situations that offered an advantage to patient care, without compromising patient safety. The trust had not completed all aspects of the PGD in line with national guidance in dermatology at the Royal South Hants Hospital.

- Nursing staff ensured prescription pads (FP10s) were locked away when clinics were not taking place. However, the systems in place at Royal South Hants Hospital for monitoring of serial numbers and the recording of each serial number issued was not entirely robust. Staff were unable to account for the number of FP10s they had at any one time, increasing the risk for a theft or loss occur.
- In diagnostic imaging, we saw appropriate systems were in place for the safe use, storage and disposal of nuclear medicines, as part of the Medicines (Administration of Radioactive Substances) regulations 1978. This included inspections by the counter terrorism unit and the environment agency.
- Medicines should be kept at the correct temperature to ensure their efficacy. Fridge temperatures were checked daily and in line with national guidance.

## Records

- Outpatient notes were a mixture of electronic and paper format. Some outpatient clinics were 'paper light' and patient records were online.
- All the records that we reviewed during inspection were of a good standard, clearly written, appropriately dated and filed.
- Staff from the patient services centre were responsible for preparing patient records for clinics, including locating, collating the referral information and ensuring the paperwork was securely stored in the correct order.
- In ophthalmology and in the main x-ray department at Southampton General Hospital, we saw patients' records stored on open trolleys in the corridor. This meant the records were easily accessible to the public and breaching patients' confidentiality.
- Within the last 12 months, there were 95 incidents in outpatients that related to documentation. Incident themes included medical notes not provided, medical notes incorrectly filed and patients not booked onto appropriate clinic. There were 616,712 outpatient appointments in the same year.

- In November 2016, the health records operational manager undertook an audit, which reviewed compliance with record retrieval and clinical record tracking. This audit looked at the process followed to retrieve and dispatch 60 record requests from July to September 2016. The audit identified that all requests, with the exception of two records (which were stored off site), were retrieved in time to meet the expectations for delivery.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and in use across the trust.

## Safeguarding

- Staff we spoke with demonstrated basic understanding of safeguarding issues but did always not know how to recognise more complex or less obvious signs of potential abuse. The hospital had a nominated lead for safeguarding children and adults, but not all of the staff we spoke with knew who this was. Instead, staff told us that they would inform the consultant if they had a safeguarding concern. This could lead to staff not following the hospital safeguarding process or a delay in referring the concern to the safeguarding lead.
- The diagnostic imaging, outpatient and physiotherapy departments did not always display clear information for staff on how to escalate a safeguarding concern. However, on the unannounced visit we saw flowcharts on wall of the orthopaedic outpatient clinic with names and contact details of safeguarding leads. Most outpatient clinics and diagnostic areas had safeguarding folders to support staff with reporting a safeguarding concern.
- Safeguarding training was part of staff mandatory training. As of March 2017, 78% of trained staff in diagnostics had received safeguarding vulnerable adult's level two training, 61% had received child protection level two training. In outpatients, staff were all above the trust target of 85% on safeguarding vulnerable adult's level two training, and child protection level three training.

## Mandatory training

- Mandatory training for staff included equality and diversity, information governance, manual handling and basic life support. Training modules were a mix of online e-learning or practical sessions. Each department we

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visited had a lead for mandatory training who reminded staff when they needed to update their training. Staff completed their mandatory training as part of their induction and then updated courses at set intervals. In March 2017, compliance ranged from 61% for basic life support to 100% compliance.

- The medical physics team provided radiation protection training for the Radiation Protection Supervisors (RPS).
- The trust compliance, for statutory fire training in January 2017 was 76.65%, below the trust target of 90%.
- The majority of staff had received 'prevent' training, 85-100%. Prevent training is the counter-terrorist programme which aims to stop people being drawn into terrorist-related activity.

## Assessing and responding to patient risk

- At Royal South Hants Hospital, the waiting rooms in the main x-ray department were separate from the reception area and staff were based in the x-ray rooms, which meant there were no staff observing patients in the waiting room. Staff only came out to the waiting area to collect patients for an x-ray. On the morning of the unannounced inspection it took 10 minutes to find a member of staff, we observed elderly patients sitting alone in the waiting area. If a patient became unwell or needed urgent assistance, there was no one to raise the alarm.
- In the radiology department at Royal South Hants hospital, there were no patient alarms in the changing cubicles. There was a patient alarm in the disabled toilet. However, this was a button on the wall opposite the toilet. There was no pull cord alarm. If a patient became distressed in the toilet, they would be unable to reach the alarm. This safety concern was raised with the trust at the time of our inspection.
- All staff were clear of the procedure to follow should a patient become unwell while visiting an outpatient clinic or diagnostic imaging department.
- There was appropriate access to resuscitation equipment in each clinical area.
- In interventional radiology, a thorough risk assessment process was followed. Prior to the procedure commencing, the clinician would use the WHO Safer Surgery Checklist to address all key clinical risks within the environment, with clear patient protocols in place.
- The last World Health Organisation (WHO) safety checklist 'Five steps to Safer Surgery' compliance audit was completed over three years ago. The trust had since

employed a consultant as National Safety Standards for Invasive Procedures (NatSSIPs) lead and was working to review the WHO checklists, and make the checklists NatSIPPs compliant. NatSIPPs standards have been developed to set out the key steps necessary to deliver safe care for patients undergoing invasive procedures and allow organisations delivering NHS-funded care to standardise the processes that underpin patient safety.

- In the imaging department, there were signs and posters in changing cubicles and waiting areas to tell women who may be pregnant to inform the radiographer before their x-ray.
- In the hydrotherapy pools area, staff we spoke with had a good understanding of emergency protocols. We observed emergency buttons in the pool area.
- Radiographers demonstrated a clear process of fast tracking any unexpected serious pathology found on an x-ray. We were informed the radiographer would discuss with a consultant radiologist and an urgent report was provided to the referrer. At the time of the visit we observed a chest x-ray organised by a GP, which showed a possible suspicious lesion. The radiographer telephoned the consultant radiologist and advised the patient to see the GP the next day for the result of the x-ray.
- There were appointed and trained Radiation Protection Supervisors (RPS) whose role was to ensure that equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- All radiology staff had personal radiation monitoring badges used for monitoring cumulative radiation. The badges had an expiry date and were sent for analysis every three months.
- In radiology, staff had a meeting every morning to discuss staffing in each department. We observed a computerised tomography (CT) scan staffing huddle, which discussed checking of resuscitation trolleys, staffing across the department, filling of staff shortages and considered supernumerary staff.

## Nursing staffing/radiography staffing

- In the outpatient department, there was no recognised national staffing model to plan staffing levels. Senior staff told us they were looking at designing a staffing

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model for outpatients. There were few vacancies across the service, only 3.5 whole time equivalent trained nurses in January 2017, and recruitment was underway to fill the vacant posts.

- In the last 12 months agency nursing staff provided 442.25 hours to the outpatient units, which was 0.29% of the total outpatient nursing workforce.
- Staff based in radiography at Southampton General Hospital rotated to Royal South Hants hospital, two to three days a month. Radiographers at Royal South Hants hospital we spoke with told us they had to cover the receptionist when they went on a break, which affected the waiting times for patients.
- In diagnostic imaging in December 2016, there was a 13% vacancy rate. Staff informed us that they were fully staffed with sonographers and overall vacancies were reduced from 13% to 6% across radiology.
- We were informed that 10 European radiographers had been recruited and their starting dates were between February and August 2017. This was also confirmed by the meeting minutes we reviewed.
- The radiology department had a Radiation Protection Advisor and each department had a Radiation Protection Supervisor.

## Medical staffing

- In most departments, nursing staff reported good levels of consultant cover for all clinics.
- Within diagnostic imaging, there were approximately 44 consultants divided into specialist areas. Consultants confirmed a good working relationship with junior doctors within the trust.
- Senior nursing staff told us that there were adequate levels of consultant cover for all outpatient clinic specialities. Consultant appointment times were allied with clinic times.
- Senior staff we spoke with told us that there was a national problem recruiting specialist radiologists and they struggled to cover interventional radiologists. Senior staff in diagnostics had put a business case together to recruit more neuro radiologists and currently had five working. The business case was to recruit an additional trainee each year.

## Major incident awareness and training

- Major incident awareness training was available to all new staff during the corporate induction programme.

- Staff were aware of their roles and responsibilities during a major incident.
- The major incident plan October 2015 for the trust included outpatients. Diagnostics and imaging departments had specific standard operating procedures, with flow charts to inform staff what to do in an emergency.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect sufficient evidence to give a rating for effective in outpatients department.

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- There was good evidence of multidisciplinary team (MDT) working practices. There were one-stop clinics to reduce the number of appointments and enable patients to receive treatment more promptly.
- Radiography staff had appropriate training for all the equipment they used and they had opportunities to develop professionally.
- Diagnostic imaging provided a 24 hour services for X-ray and a computerised tomography (CT) scans overnight and at the weekends. Seven day outpatient services were not available.

However,

Throughout the outpatient and radiology departments, not all staff had a full understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, which ensure decisions are made in patients' best interests.

## Evidence-based care and treatment

- The trust had a clinical effectiveness and outcomes steering group (CEOSG) which monitored compliance of National Institute for Health and Clinical Excellence (NICE) guidance and quality standards. Monthly spreadsheets of new NICE guidance and quality standards were sent to the CEOSG. Any new guidance was raised at the CEOSG meetings and leads were

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identified. Some examples of the NICE guidance and quality standards used were Glaucoma in adults QS7, in ophthalmology, and head injury: assessment and early management Clinical guideline 176 in radiology.

- The physiotherapy department followed The Chartered Society of Physiotherapists guidelines on good practice in hydrotherapy.
- Research and specialist nurses kept outpatient staff up to date with all relevant local and national guidelines for each specialty.
- There was good evidence of adherence to local policies in diagnostic imaging. For example, the 'pause and check' system to ensure the correct identification of patients prior to imaging was observed to be used in everyday practice.

## Pain relief

- Staff in the outpatient department discussed pain and options for pain relief with the patients during consultations.
- Patients undergoing procedures in outpatients were given advice on pain management prior to their procedure.

## Patient outcomes

- From April 2015 to March 2016, the follow-up to new rate for Southampton General Hospital was higher than the England average.
- The diagnostic imaging department did not currently take part in the Imaging Services Accreditation Scheme (ISAS); however, they told us they had plans to gain accreditation. ISAS is a patient-focused accreditation scheme that helps imaging services to manage the quality of their services and make continuous improvements.
- IR(ME)R audits were undertaken as required by the regulations, including a patient identification audit. The outcome of this audit and a similar audit, operator knowledge of procedures and responsibilities resulted in IR(ME)R updates being included at induction and shared at appraisals.
- Senior staff in diagnostic imaging monitored the length of time images were reviewed and reported. All trauma, plain film and Magnetic resonance imaging (MRI) that were not reported after two days were sent to an external tele radiology provider.

## Competent staff

- Patients told us they felt staff were competent to provide the care they needed. This was confirmed by staff who told us they felt supported to maintain and develop their professional skills and experience.
- Nursing staff told us they were aware of their responsibilities around revalidation and were being supported by their manager. This included ensuring staff personal files were up-to-date and contained information on all trainings they had attended.
- Nursing staff, healthcare assistants and administrators from each outpatient specialty were offered training opportunities to develop professionally and gain the latest skills and knowledge relevant to their post. However, it was sometimes difficult for staff to be released for training because of staffing shortages.
- All new starters in radiology went through an induction process and competency assessment. We saw a completed competency portfolio.
- New starters in radiology worked through a range of shifts including being second on call and spent three months being supernumerary on each scanner for example MRI, computerised tomography (CT) scan.
- There was an educational lead for radiology and radiology staff had weekly lunchtime teaching.
- All staff had yearly appraisals. Staff who we spoke with felt their appraisal was positive with development plans for the future. Members of staff said the appraisal was informal which allowed them time to discuss their progress and any development plans. As part of the appraisals process, all staff at band 7 or above had 360-degree feedback. Consultants had 360-degree feedback at least once every three years as part of their revalidation.
- All physiotherapists who wished to request x-rays were trained in radiation protection by the medical physics team. Evidence of the training programme and requirements for entry onto the training were observed during inspection.
- The medical physics team provided radiation protection training for the Radiation Protection Supervisors (RPS).
- Staff administering radiation had received appropriate training for their role. The department was compliant with the requirements of Medicines (Administration of Radioactive Substances) Regulations (MARS) in relation to the administration of radioactive medicinal substances.

## Multidisciplinary working

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- We observed and saw evidence in patients' records and staff told us that there was effective multi-disciplinary (MDT) working within teams and with other teams, both internally and externally.
- In the cardiology and age-related macular degeneration clinics, one-stop clinics were held to enable patients to access a number of services on the same day, reducing the number of appointments and providing quicker access to a diagnosis and treatment. All these clinics involved medical staff working with nursing or allied health professionals.
- In diagnostic imaging, staff obtained previous scan results for patients where possible, to avoid unnecessary exposure to radiation. The trust used an electronic request and results system, which was available, nationally, so they could access results from tests performed at other hospitals.
- All nursing staff across the outpatients department told us they had good working relationships with the consultants from each speciality. They felt on-going communication with medical colleagues improved a patient's experience within the department.

## Seven-day services

- Outpatient appointments were available Monday to Friday between 9am and 5pm. Some specialties offered appointments later in the evening but this was not standard practice across outpatients as a whole. In ophthalmology, waiting list initiative clinics were held on Saturday mornings.
- Radiography and imaging provided a full, seven day on call service. The diagnostic imaging service provided a consultant on-call service seven days per week for CT and ultrasound. The standard CT and MRI service ran from 8am to midnight, with additional clinics held on weekends and bank holidays 8am to 5pm. A radiologist was on call 24 hours to come in from home and for telephone advice.
- Patients received access to diagnostic tests with a 24 hour turnaround time. For urgent requests, this dropped to 12 hours and for critical patients, one hour.
- At Royal South Hants hospital, the radiology services operated Monday to Friday. A weekend service was not provided. There were no outpatient's clinics at weekends, which would require x-ray services.

- The patient service centre was responsible for booking all new outpatient appointments and most follow-up appointments they were available from 8am to 8pm, Monday to Friday and Saturday mornings.

## Access to information

- The trust used an external provider to convert clinician dictation into typed letters, which were checked by trust employees before being sent to GPs. The provider supplied monthly reports, broken down by speciality, this showed detailed timescales of when letters were produced by the clinic, administrators, the initial typing time and subsequent checking and approval.
- In line with the trusts transfer of and discharge care protocols, following an outpatient attendance, the GP should receive information within seven days. The average completion time in all of the outpatients departments in September 2016 was four calendar days.
- In radiology, all internal referrals were made via an electronic referral system. Electronic requests were automatically recorded on the radiology information system and allocated to pre-agreed pathways for vetting. The vetting process included clinical approval, radiation safety justification, recommended protocols or special instructions.
- GP requests for radiology were paper based. Completed reports were printed and sent by post to GPs.

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

- Not all staff had an understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Some staff had received training and could explain in comprehensive terms how the legislation affected their patients and what their responsibilities were. In diagnostics, 83% of trained staff and 63% of healthcare assistants had received MCA and DoLS training. In outpatients, all staff were fully compliant with MCA and DoLS training. The trust target was 85%.
- Staff described and we saw in patient records that consent had been sought and documented prior to procedures or diagnostic tests being performed. Consent was either gained verbally or recorded or for more complex procedures, a consent form was

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completed. We checked two consent forms and they had been filled in correctly, including the risks and benefits of the planned procedure. Patients told us they felt fully informed prior to giving consent.

- In diagnostic imaging, pregnant women completed a specific consent form, prior to an MRI scan being performed.

## Are outpatient and diagnostic imaging services caring?

Good 

We rated caring as good because:

- Patients told us that they were included in the decision making regarding their care and treatment. Staff demonstrated good communication skills and made patients feel welcome within the hospital.
- Patients described how the emotional care and support provided to them was extended to relatives who had accompanied them to appointments.
- Nurses greeted patients warmly in outpatient clinics and introduced themselves.
- Chaperone signs were on display in waiting areas and we observed staff asking patients respectfully if they required a chaperone during their consultations, to protect their dignity.

### Compassionate care

- All patients we spoke with were happy with the quality of care they had received. Patients told us that staff were very caring and informative. One patient told us that staff, "Tell you everything they are doing".
- In radiology, one patient we spoke with told us, "Everything has been great, everyone is so kind and nothing is too much trouble. Staff seem to know what you have been told so you don't have to repeat yourself".
- We observed all staff to be courteous, professional and kind when interacting with patients. We observed staff greet patients appropriately, and introduce themselves by name.
- In radiology at Southampton General Hospital, inpatients and outpatients waited in separate areas to protect privacy and dignity.

- Staff ensured confidentiality and privacy by knocking and waiting for a response before entering the consultation or treatment room. We saw doors and curtains were kept closed during consultations or while staff were providing care.
- The layout of the majority of reception areas meant conversations between patients and the reception staff could at times be overheard but we observed that reception staff spoke to patients discreetly in an effort to maintain confidentiality.
- Chaperone signs were displayed across outpatient and diagnostic imaging waiting areas. Staff were observed asking patients if they required a chaperone during consultations.

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

- Staff in the department communicated with patients about their care and treatment in a way they could understand. All the patients we spoke to felt well informed and involved in the decision making regarding their care and treatment from start to finish.
- Patients and carers told us all staff had given clear explanations, in sufficient detail for each stage of their care and treatment. We were informed, "Staff make sure you understand exactly what is going on, the surgeon came out and explained everything to my husband".
- The majority of patients we spoke with either had their next appointment date when they left the clinic or knew this would be sent to them. Patients told us test results were sent to their GP who would contact them if necessary or results would be discussed at their next appointment.
- Patients were aware of whom to contact if they were concerned about their appointments, and contact details were available on letters.

### Emotional support

- Staff in busy clinics took the time to offer emotional support to patients when needed. Staff were seen to show empathy and compassion to patients. However, we did observe nursing staff did not always recognise when patients might need some additional assistance. For example, we saw where patients were distressed and the staff did not recognise the patients concerns.
- At Royal South Hants Hospital, a volunteer at the reception desk helped patients with directions to find their way around the hospital.

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- A patient we spoke with told us “if I am unhappy or uncomfortable they know and make sure they act on it. All the staff introduced themselves in the procedure room before the procedure started”. “Staff arranged for me to have medication to be given before they commenced the procedure as they were aware that I was scared of needles”.
- Patients were seen by clinical nurse specialists in a number of specialities such as urology and dermatology outpatients, so patients could seek additional expertise, advice and support.

## Are outpatient and diagnostic imaging services responsive?

Good



We rated responsive as good because:

- The outpatient, imaging and physiotherapy departments all planned services around the needs and demands of local people.
- The service overall met referral to treatment time targets (RTT) and consistently achieved the two-week wait for urgent cancer referrals. Work had been completed in a number of specialities, including ophthalmology, to help them achieve the RTT target.
- There were initiatives in place to reduce the number of patients who did not attend or cancelled their appointment. These were effective and the trust achieved or performed better than national targets for these areas. The patients’ access team worked hard to ensure clinic profiles were correct and patients were booked to the appropriate clinic at the correct time.
- There were appropriate facilities available for patients attending appointments, including those with additional needs. Patients had access to interpreters.

However:

- There was no signage available for patients who did not speak English as their first language and no information leaflets were available in any other languages. We were informed that they were in the process of developing new signs.
- The self-service touch screen “booking-in” was not fully user friendly and staff did not always know patients when patients had arrived.

## Service planning and delivery to meet the needs of local people

- Each outpatient department was managed by the care group to which the speciality belonged. They were responsible for planning and running its corresponding outpatients service, with oversight from the care group leads.
- Managers we spoke with identified the key needs for people accessing their service and how these were currently being achieved and managed. Managers had development plans so their service could continue to meet the needs of the local population served by the trust.
- Most outpatient clinics were held at University Hospital Southampton, with clinics also held at Royal South Hants Hospital and the Princess Anne Hospital.
- The patient service centre was responsible for booking all new outpatient appointments and most follow-up appointments. They were open 8am until 8pm, Monday to Friday, and on Saturday mornings. This was to ensure that patients who wanted to book appointments could arrange them when they got home from work.
- The outpatients departments at Southampton General Hospital were based in different areas of the hospital; there was no single outpatients department. The outpatients clinic on E level was along a busy thoroughfare.

## Access and flow

- In each outpatient reception area, there was a self-service touch screen booking in facility available. This consisted of 13 pages and if patients did not complete each page, they were not fully registered as booked in. We observed four patients who did not complete this process. This meant that some patients were sitting in the waiting area and staff were not always aware they had arrived. At the Royal South Hants Hospital, the internet could be intermittent and sometimes did not recognise when patients booked in.
- The patient service centre had its own monthly targets to answer calls within 75 seconds. This was audited and results disseminated to team leads to inform plans to improve performance. The centre was meeting the 75 seconds target. Most patients said they did not have any difficulty getting through to the patient service centre to arrange or reschedule appointments.

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- The outpatient department did not carry out audits on how long patients had to wait in the department for their consultation.
- There was a walk in service at Royal South Hants Hospital for GP patients who required a chest x-ray and an appointment system for all other departments.
- From November 2015 to October 2016, the trust's referral to treatment time (RTT) for non-admitted pathways had been generally worse than the England average. The latest figures from October 2016 showed 90.6% of this group of patients were treated within 18 weeks versus the England average of 89.4%. The trust was showing a trend of improved performance against the national performance.
- From November 2015 to October 2016, the trust's referral to treatment time (RTT) for incomplete pathways was better than the England overall performance and better than the operational standard of 92%. The latest figures for October 2016 showed 92.1% of this group of patients were treated within 18 weeks versus the England average of 90.1%.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- For the period July 2016 to October 2016, the national standards for cancer wait times were being met and the trust was consistently above the standard. This included 94% of people whose first consultant appointment was within two weeks of an urgent GP referral and 97% of people waited one month from a decision to treat to a first treatment for cancer. Eighty six percent of patients waited at most two months from urgent GP referral for a first treatment for cancer wait clinics.
- The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- The trust was performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.
- From November 2015 to October 2016 the percentage of patients, waiting more than six weeks to see a clinician was lower than the England average.
- From April 2015 to March 2016, the 'did not attend' rate for Southampton General Hospital was lower than the England average. Phone calls and texts were used to remind patients of appointments.
- Patients told us that the availability of appointments was good and appointments were provided at times that met their needs. Patients were complimentary about the efficiency of the service as a whole.
- The waiting times for patients from arrival in the outpatient department until their consultation varied. In all clinics, there were whiteboards displaying the current waiting times for patients.
- All outpatient waiting areas had boards advising patients of any delays to the clinics which were running. We observed in four departments these boards being updated and where there were significant delays, staff took the time to speak with patients to keep them informed. Reception staff also advised patients of delays when they arrived.
- The outpatients nursing staff at University Hospital Southampton raised concerns about patients using hospital transport arriving late for appointments or being collected more than an hour after their appointment had finished. Transport to and from hospital was provided by an external provider. Staff however did not log these delays as an incident, nor were they aware of any local audits so this information could be shared with the provider.
- Patients fed back that the 'car parking was a big problem' from outpatient to inpatient and it affected their experience.

## Meeting people's individual needs

- The outpatients and diagnostic imaging departments had adequate seating arrangements for patients to sit and wait for appointments, X-rays and scans.
- The layout of the departments we visited meant all areas were accessible for people in a wheelchair or with limited mobility. However, at Royal South Hants Hospital in main x-ray, the disabled changing room was small and there was not enough room to allow access for a wheelchair.
- Staff in ophthalmology recognised the need to support people with complex or additional needs and made adjustments wherever possible for example prioritising patients living with dementia or learning disabilities.
- The outpatient departments, which still had paper records did not have a formal system of recording or highlighting patients who had additional needs. One member of staff told us it was possible to place a note on the patient's record but this did not always happen.

# Outpatients and diagnostic imaging

- Trust staff with existing foreign language skills could undertake a course with a final assessment to become a trust-wide translator. Staff told us this system worked well. It was also possible to book an interpreter through the language line facility.
- Care group leaders informed us that if patients needed assistance with translation or communication there were posters displayed around the trust. However, we did not see any evidence of leaflets or signage available in any other language or format.
- Staff in diagnostic imaging told us that they were able to access a learning disability specialist nurse who supported the trust in caring for patients with a learning disability.
- At Royal South Hants Hospital the orthopaedic outpatients department had a dedicated latex free room for patients who were allergic to latex.
- Staff told us that the clinic could be noisy and they were concerned that if patients were being given sensitive information in the consulting rooms they would not be able to hear. We observed noisy trolleys being pushed through the corridor. On the unannounced visit, we observed that a room away from the corridor had been designated as a quiet room.
- Governance processes were well developed to manage risk and quality. Information about incidents and patient experience was shared among staff within each department.
- Risk registers for all departments were available on the staff intranet so all staff could be aware of any risks or issues.
- Nurses and radiographers knew and put into practice the service's values and they knew and had contact with managers at all levels, including the most senior. They told us they felt well supported and valued.
- Staff engagement was encouraged in diagnostic imaging, where 'listening clinics' were held fortnightly to gain feedback from staff and to further develop the service.

However:

- Staff in outpatients told us they did not have regular meetings, and they did not have an understanding of the strategy for outpatients or how they could effect change within it.

## Leadership of service

- In radiology and diagnostics there were superintendent clinical leads for each modality and a superintendent responsible for each area. The lead superintendents reported to the head of radiology.
- We were informed that the superintendent team had changed since the last inspection and there was good leadership and training provided for superintendents.
- All the radiologists we spoke with described good working relationships with their line managers and with the executive team, especially the clinical director and service manager.
- The outpatients department was led by a head of outpatients and matron. Physiotherapists and nurses in outpatients spoke highly of their immediate line managers.
- They continually told us they felt well supported and valued. Staff felt confident they could go to their direct supervisors with any concerns or feedback they might have, and that it would be acted upon fairly and professionally.
- Staff we spoke with told us they felt very fortunate with trust leadership. We were told, "The chief executive officer motivates and inspires people and listens, no matter what band you are or who you are".

## Learning from complaints and concerns

- From July 2015 to June 2016, there were 150 complaints about the outpatient service at the trust and nine complaints about the clinical treatment 'Radiology group'. We reviewed the complaints and there were no themes or trends.
- The trust has a policy in place for the management of complaints. The Chief Executive Officer sees and signs off all complaints.
- Information for patients on how to leave feedback or make a complaint was provided in waiting areas. Patients told us they would speak to a member of staff if they had concerns but none of them had made a complaint, as their care had been good.

## Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

# Outpatients and diagnostic imaging

- All staff felt the Chief Executive Officer and the divisional management team were accessible and visible.

## Vision and strategy for this service

- The University Hospital Southampton, two year operational plan 2017 to 2019 was for the volume of outpatient attendances to reduce, with more new outpatients and less follow up patients as more digital and virtual appointments were introduced. The trust had set a target to reduce outpatient face to face attendances by 20% over the next five years and improve “did not attend rates”. This target was to be achieved with the introduction of out of hours clinics, three more clinic sessions, telephone clinics and developing an outpatients website for them to access up to date information.
- The trust values were, ‘putting patients first’, ‘working together’ and ‘always improving’. Staff we spoke with were aware of the values. Staff in radiology told us the values were lived by staff in the department for example, by ‘putting patients first’ was demonstrated when the department was busy and a patient needed something urgently then staff would delay their lunch break.
- Senior staff in radiology told us their vision was to upgrade all rooms, this had been completed at the main x-ray at Royal South Hants Hospital.
- Staff in outpatients were unable to tell us the strategy for outpatients or how they could affect change within it. They did however, have a good understanding of the trust vision and values.

## Governance, risk management and quality measurement

- The trust’s quality improvement governance systems were through the care group governance groups, which reported to the divisional governance groups. The trust quality governance steering group (QGSG) reported to the trust executive committee, and ultimately to the trust board.
- There was no specific directorate or management structure for outpatients as they were managed within each care group.
- The clinical governance manager held transformation meetings with the executive team every month. We were told information was cascaded both up and down from the executive team.

- In radiology governance, meetings were held monthly and the radiology protection committee met every three months. Both meetings had set agendas and fed into radiology meetings.
- Governance meetings in radiology were held before divisional governance meetings. Staff we spoke with told us that minutes from these meetings were placed on noticeboards. If there was relevant information for a team then it would be cascaded through email and team meetings.
- Staff who worked in the magnetic resonance imaging (MRI) department had introduced MRI protocol meetings. Staff told us that, previously if a consultant wanted to adapt a protocol they would ask a radiographer and this would have been changed but not followed through or consistent. Now, staff or consultants can email the protocol inbox with changes and improvements and this would be discussed at the meeting. Radiographers and medical physics staff would attend.
- The radiology risk register was effectively managed through the radiology clinical governance meetings and reviewed every two months. This was available on the staff intranet so all staff could access and be aware of issues on the risk register. We were informed items were not removed from the risk register until they were fully resolved. For example, the age of equipment and environment was being dealt with through refurbishment but would not be removed until the work was completed.
- The trust wide risk register, highlighted concerns within outpatients such as insufficient capacity to cope with increased demand on the dermatology service, the national shortage of dermatology consultants and the lack of nursing staff with appropriate skills to carry out nurse led services. Insufficient clinical space within the ophthalmology outpatient department. Additional outpatient clinics were being held during evening and weekends to mitigate this.
- The outpatients’ senior nurses forum met bi-monthly. They discussed local and national topics, which included capacity, staffing models, skill mix and raising their profile within the trust.

## Culture within the service

# Outpatients and diagnostic imaging

- All of the staff we spoke with within outpatients and diagnostic imaging told us that the teams they worked in and the supportive relationships forged with their colleagues were the main reasons they enjoyed working for the trust.
- There was an effective process to support staff working in the patient service centre, who were sometimes verbally abused by patients during calls. Staff also completed customer care training to help them manage patients who became angry or frustrated.
- Some outpatient staff at Royal South Hants Hospital felt disconnected from the wider trust and felt their service was not always considered. However, they enjoyed working at the hospital and all supported each other.
- In radiology, staff we spoke with told us that they were currently looking at the rotas and flexible working, potentially changing shifts, and that there was a survey out to staff to find out their preferences.
- Staff were encouraged to complete the NHS staff survey in 2015, 68% of staff would "recommend my organisation as a place to work" above the national average of 61%.
- The trust recognised the hard work of staff through annual staff awards called "hospital heroes". In 2015, the outpatient transformation team won the innovation award.
- The physiotherapy department offered a self-referral scheme for staff to the musculoskeletal physiotherapy service.

## Public engagement

- There was evidence that the hospital acted upon patient feedback to help improve their service. For example, "you said we did" boards were seen in radiology and ophthalmology.
- The results of the Friends and Family Test (FFT) in January 2017 showed 97% of patients would be 'likely' or 'extremely likely' to recommend the hospital to their friends and family. FFT response rates were above the England average (95%).

## Staff engagement

- Nursing staff we spoke with in outpatients told us they were not having regular team meetings.
- The radiology manager and the care group manager held drop in forums for staff called a listening clinic every two weeks, allowing radiology staff to air and share their concerns.
- The Chief Operating Officer wrote a monthly bulletin. Staff we spoke with felt it was written in a way that made staff want to read it. The Chief Operating Officer attended the lead superintendent meetings to talk about radiology specific topics, finance and trust issues.
- The CEO wrote a monthly blog and would also send out a core brief each month, which covered performance, finance and patient experience.

## Innovation, improvement and sustainability

- The head of radiography, supported by the radiology governance facilitator was working towards and using the imaging services accreditation scheme (ISAS) standards as a guide to meeting accreditation standards before applying for a formal application.
- Cardiothoracic radiology is one of six sections of the radiology care group, providing radiological expertise for the Wessex cardiothoracic centre.
- Each care group clinical team was invited to present their transformational ideas to the executive team.
- University Hospital Southampton NHS Foundation Trust is the only UK hospital providing intraoperative radiotherapy.
- The trust had a Commissioning for Quality and Innovation (CQUIN) project with their commissioners that aimed in transforming the experience of outpatients This CQUIN was intended to enable the trust to review current practice of routine face to face follow up after in-patient episode, first outpatient episode or urgent attendance and to explore opportunities to work differently.

# Outstanding practice and areas for improvement

## Outstanding practice

- There were outstanding examples of multidisciplinary team working and communication with safe patient care at the forefront of handovers.
- The hospital has a large volunteer body of over 1000 people involved in diverse activities to support the hospital and its' patients. Some of the volunteers work as mealtime assistants to support those who need extra help or time to eat.
- The neurological intensive care unit had developed sophisticated strategies to ensure the continued wellbeing of their patients who presented with challenging behaviour when cared for within an acute clinical environment. This benefitted not just patients, but also protected relatives and staff from the possibility of unintentional violence.
- An early mobilisation programme initiated by the physiotherapy service on GICU, had won a Health Service Journal Value in Health Care Award. This was now carried out on Neuro ICU and had reduced the length of stay in the critical care setting and hospital for patients due to the success of this programme.
- Care for patients across critical care was outstanding. Patients' needs were considered at all times, and a high level of support was provided for the emotional and spiritual needs of family members and patients.
- The critical care service worked closely with the palliative care team to provide timely and empathetic support for patients whose conditions would not improve. This service, in supporting decision making, had enabled 200 patients to appropriately enter an End of Life care pathway.
- The success of a respiratory education package developed by the education team aimed at the full multidisciplinary team had resulted in it being adopted trust wide.
- Neuro ICU worked closely with manufacturers to support development of service specific equipment. This included working with an overseas company to develop and improve intracranial pressure monitoring equipment and working with the provider of lateral rotating beds for patients with spinal injuries to best meet the needs of patients and reduce risk of injury of staff during complex moving and handling procedures for these patients.
- In Neuro ICU, the mobile head CT scanner was reducing the need for patients to be transferred across the hospital, out of hours, for CT head scans.
- University Hospital Southampton NHS Foundation Trust is the only UK hospital providing intra-operative radiotherapy.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the hospital MUST take to improve

- Reduce the number of mixed sex accommodations across the trust to improve privacy and dignity for patients.
- The trust must ensure medicines are always stored at temperatures that ensure their effectiveness.

### Action the hospital SHOULD take to improve

- Review the equipment safety testing process, so that all equipment is safety tested.
- Ensure records in the critical care and outpatient departments are always stored securely to protect patient confidentiality.

- Learn from incidents and share feedback across divisions.
- Review the ways in which patient information and records is stored on the wards and in departments to ensure better security.
- Ensure that staff receive Mental Capacity and DoLS training.
- Ensure all staff are trained in safeguarding children to the levels required by their roles.
- Improve processes to reduce the number of patients cancelled for surgery and ensure any cancelled patients are booked back in within 28 days.
- Improve access to pressure relieving mattresses.

# Outstanding practice and areas for improvement

- Review and improve the method by which pressure ulcers are reported. If reporting numbers decrease, they need to action and investigate this.
- Review and improve the timescales of ward repairs.
- Review the equipment safety testing process, so that all equipment is safety tested and labels if used are updated.
- Review the practice of using open topped waste bins in anaesthetic rooms.
- Consider making a private room available for urological confidential discussions.
- Review the IT system used for recording training due to issues with storing training data.
- Review the concerns raised by patients regarding the hospital food provided, and make improvements.
- Improve daily checks across clinical areas on resuscitation equipment.
- Improve compliance with mandatory training to ensure this meets the trust target.
- Review the discharge information provided by the electronic recording system so that receiving wards and hospitals have all the information they need so the patient receives seamless care and treatment.
- Consider the Royal Pharmaceutical Society guidance and the Standards for Intensive Care Units as to whether a critical care pharmacist should be available outside core working hours.
- Ensure DNACPR forms are completed in line with national guidance and best practice recommendations.
- Review the consultant palliative care cover in line with national recommendations.
- Ensure all relevant nursing staff receive formal competency assessment training on use of the syringe driver.
- Improve the rapid discharge pathway to increase the proportion of patients who are able to die in their preferred place of death.
- Consider auditing the views of the bereaved as recommended by the end of life care-dying in hospital audit 2016.
- Ensure prescription pads are maintained appropriately with necessary audit trail detailing storage and issuing of prescriptions.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

| Regulated activity  | Regulation   |
|---|--|
| Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br><b>How this was not being met</b><br><br>Patients were not able to consistently access clearly labelled gender- specific toilet and bathroom facilities as arrangements were not consistently implemented.<br><br>Patients were sometimes sleeping in mixed sex bays in the acute surgical unit. |