

Hampshire Hospitals NHS Foundation Trust

Evidence appendix

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

Facts and data about this trust

Acute hospital sites at the trust

Hampshire Hospitals NHS Foundation Trust provides general hospital and some specialist services to a population of approximately 570,000 people across Hampshire and parts of west Berkshire, and to patients from much further afield for some specialist services. The population is predominantly rural, with urban areas in Basingstoke, Winchester, Andover, Eastleigh and Alton.

The trust has three acute hospital sites, shown in the table below:

Name of acute hospital site	Address	Details of any specialist services provided	Geographical area served
Basingstoke and North Hampshire Hospital	Aldermaston Road, Basingstoke, RG24 9NA	Accident and emergency department, cardiology, emergency same day care unit, gastroenterology, neurology, peritoneal malignancy unit and rheumatology.	Basingstoke and North Hampshire
Royal Hampshire County Hospital	Romsey Road, Winchester, SO22 5DG	Accident and emergency department, cardiology, community geriatrician service, emergency same day care unit, gastroenterology, hyper	Winchester and Eastleigh

		acute stroke unit, neurology ophthalmology, and rheumatology.	
Andover War Memorial Hospital	Charlton Road, Andover, SP10 3LB	Cataract and minor eye surgery, dermatology, dietetics, endoscopy, haematology, minor injuries unit, neurology, outpatients, rheumatology and urology.	Andover

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

Is this organisation well-led?

Leadership

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

The trust board had the appropriate range of skills, knowledge and experience to perform its role. There had been changes to board membership since our last inspection. We heard from a cohesive and passionate newly formed board. Board changes since our last inspection included the chairman (January 2019), chief medical officer (September 2019), chief nurse (September 2018) and new non-executive directors (April 2019). An additional director role, the Director of Strategy was created and appointed to in 2018. Despite these changes, the board had demonstrated stable leadership.

At the time of our inspection, the trust was advertising for a programme director to help deliver on the health infrastructure plan which is a long-term, rolling five-year government programme of investment in health infrastructure. The board had acknowledged they required specialist expertise to start phase two of this plan.

The senior leadership team had a high degree of confidence in the chairman to focus on strategic ambitions and described how he had brought new ideas and different ways of working to the team. Since our 2018 inspection, the trust had focused on continuing its improvement journey through strengthened clinical leadership and a focus on key aspects of performance. Examples of improvement included, meeting all but one national cancer targets in quarter three, improved access to antibiotics within one hour of sepsis diagnosis and reduced non-elective length of stay by one day in one year.

The trust recognised that it needed to ensure it had appropriate financial capacity and capability at all levels to support it achieving financial improvements. Staff told us additional recruitment to the finance team was planned as well as two additional non-executive directors. This would enable the trust to review its board committees and membership to ensure they have the appropriate skills with which to discharge their responsibilities.

In addition, the trust had recently appointed an interim head of programme management office to support the delivery of its cost improvement programme. To avoid gaps or overlaps, the trust

needed to ensure that the role of the project management office, along with its relationship to other improvement functions, was clear.

The board had five non-executive members. They had a wide variety of skills and experience including financial, business, operations, leadership, military, public sector, and both executive and non-executive board experience. At our last inspection, we saw none of the non-executive board members had a clinical background. In April 2019, the trust appointed two non-executive members with clinical backgrounds. We heard how this had improved independent clinical challenge at board level. After observing the board and interviewing board members we felt assured that respectful challenge had become common practice. They reported they had developed better relationships with the governors through more engagement. Interactions now felt far more inclusive and open. They were supportive of the chairman's driver to minimise private meetings and to have as much as possible in the public domain.

At our 2018 inspection, board meeting minutes were brief and did not provide evidence that constructive challenge took place. At this inspection, we reviewed the last three months of board meeting minutes which showed there was a high level of challenge. We observed the private and public board meetings (held in January 2020) and noted that all board members were present and contributed to discussions. We noted the chairman conducted the board meeting effectively and ensured that discussion and challenge was respectfully maintained. Non-executive directors were knowledgeable about the issues discussed and were equal in contribution to the decision making. It was clear members had read the papers prior to the meeting as they came prepared with their questions which enabled timely discussion.

As a foundation trust there was a council of governors. We spoke four governors who reported they had an open door to the chairman and chief executive officer who valued the input of the governors. Channels of communication had improved, and they felt able to hold non-executive directors to account. The governors had recently completed a skills audit to enable the right skill set to be aligned to individual non-executive directors.

There was a programme of board visits to services and staff fed back that leaders were approachable. The senior leadership team undertook regular safety walk arounds at all three sites. Trust data showed between January and September 2019, the executive team undertook 13 walk arounds, the chairman undertook 60 walkarounds and the non-executive directors undertook 31 walkarounds. There were also trolley dashes where leaders would go to departments and wards to encourage staff engagement for instance with the staff survey. Staff fed back that they felt leaders were visible and approachable. Staff we spoke to on the core service inspection generally felt that senior leaders were approachable, however some clinical staff reported they were not aware of who the executive team were.

The trust leadership team mostly had a comprehensive knowledge of current priorities and challenges and acted to address them. Where some issues had been raised during the core service inspection, the trust took immediate action to address these. As is the case in most NHS trusts, there were significant tensions between quality and sustainability in leading the trust to meet its commitments and vision within its means. The senior leadership team considered and acknowledged these issues throughout their processes and meetings. Balancing quality and sustainability were a thread throughout the board's work. Board papers, minutes of board and committee meetings showed the senior leadership team discussed the efficiency and quality of services. Topics discussed included reconfiguration of services, seven-day services, winter pressures, new contracts, corporate strategy and the NHS long term plan. Board members were involved broadly in discussions both within their areas of expertise and outside.

However, not all of the leadership team had the correct skills and experience for their role. Upon discussions, it was clear some members did not have a full grasp of their portfolio and did not undertake good practice which could affect the effectiveness of the leadership team.

To identify challenges to quality of care and actions to address them, in July 2018, the trust worked with NHS Improvement and took part in the 'Getting it Right First Time' (GiRFT) programme. The recommendations following the review identified changes to help improve care and patient outcomes as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. The business case to align services to a hot and cold model of care with trauma work concentrated on one site and elective work on the other was presented to the board in September 2019. The papers demonstrated how quality and sustainability had been reviewed and considered for all options.

Board members understood the risks related to non-clinical aspects of trust infrastructure. For instance, the leadership team recognised the direct impact of estates and facilities on patient experience and the quality of care. Staff told us estates was problematic not only because there were three sites, but also the age and composition of these buildings. In response to this risk, the trust, in March 2019, developed an estates strategy which complimented their estate and refurbishment programme. However, senior staff acknowledged that although they had visibility and actions in place, actual solutions were difficult to achieve due to time and funding restraints.

Specialist leadership was generally accessible across the trust. Although, during the core service inspection we noted there was a lack of pharmacy oversight and dedicated ward pharmacists. The trust had a chief pharmacist who was new in post and had escalated the gaps in ward cover to the senior leadership team. The Chief Pharmacist told us ward cover was part of the clinical strategy and a work force plan was in place. Pharmacy were allowed to over recruit, had recruited a group of pharmacists on the bank and reported better turnover rates due to investment in training and education.

Leadership development opportunities were available, including opportunities for staff below team manager level. The trust had a three-year organisation development and leadership strategy which showed all staff had access to in house training in leadership/management skills and could receive support through coaching. The trust supported managers and leaders to seek additional development opportunities through the NHS leadership academy. There were targeted development opportunities for specific groups such as clinical matrons, clinical band 6 and 7 staff. Between, October 2018 and September 2019, 359 members of staff had participated in a leadership development programme. Our interviews with the senior leadership team showed they recognised their training needs and in 2019 a system leadership programme was launched for the board and the executive team. This was externally facilitated and there were participants from 24 different organisations providing care in North and Mid Hampshire. The team received training every month and topics included constructive challenge, governors roles and culture change.

Succession planning was in place throughout the trust. The trust addressed succession planning through programmes to grow their own staff. For example, the trust had supported healthcare support workers into nursing roles and used deputy roles for key posts such as deputy operations directors and associate directors to stretch high potential employees. A paper on succession planning was presented to the nomination committee on 10 June 2019. It showed formal succession planning had been undertaken with the board in February 2019 and reviewed in May 2019. This was due to be rolled out to the next level down within the structure.

Each board member should go through a rigorous recruitment process to verify they had the skills, knowledge and experience for the role. This is known as the Fit and Proper Person Requirement

(FPPR) (Regulation 5, HSCA, 2014). The trust policy for FPPR outlined what information should be held for each senior leadership team member and how often checks will be undertaken. The company secretary monitored compliance with the FPPR policy while the chairman had overall responsibility.

At the last inspection, we stated the trust must ensure that all FPPR checks are carried out at appointment and reviewed on an annual basis and that evidence of these reviews is documented. On this inspection, we found the trust did not have an effective system to review FPPR because documentation was missing from some director files. At this inspection, there was still a lack of compliance by the trust with meeting FPPR despite the introduction of a monthly compliance checklist. We reviewed six directors' files and found inconsistencies between the contents of the files and the completed checklists. For example, only three files had evidence of completed reference checks, one file did not have evidence of a *Disclosure and Barring Service (DBS) check*, only half of the eligible director files had evidence of completed professional checks and only three files had evidence of an occupational health check, despite directors undertaking regular engagement activities in clinical areas. The checklist for these files showed 100% compliance which meant the trust did not have enough evidence to show a robust recruitment process. All director files had evidence of employment history and a yearly appraisal.

Board Members

Of the executive board members, 14% were Black and Minority Ethnic (BME) and six (86%) were female.

None of the non-executive board members were BME and two (29%) were female.

Staff group	BME %	Female %
Executive directors	14%	86%
Non-executive directors	0%	29%
All board members	7%	57%

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

Vision and strategy

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

The trust had a clear vision and set of values with quality and sustainability as the top priorities.

Since the creation of the trust in 2012, its vision was for a critical treatment hospital between the Basingstoke and Winchester sites, which was not able to be realised because of concerns regarding the affordability of the plans. Some staff reported the trust had lost focus, in its desire and push for a new hospital. Following the appointment of a director of strategy and partnerships in 2018, the trust embarked on a strategy development process which included understanding requirements from the NHS long term plan, system wide engagement with Hampshire and Isle of Wight STP (Integrated Care System) and the North and Mid Hampshire Local Care Partnership (Integrate Care Provider) and engaging staff by speciality as part of the business planning cycle.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The trust's vision and current strategic objectives were approved in 2018 and spans over four years. The trust consulted with staff, governors, clinical and non-clinical leaders, unions, partners and stakeholders. Staff contributed through a bespoke email account, through Facebook and face-to-face at 'In Touch' sessions. Strategic objectives were tested with different groups by the chief executive officer and other leaders and feedback was considered.

There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. The trust's vision was to provide outstanding care for every patient. To do this the trust had four high level strategic objectives which were; outstanding care for our patients, empowered people living within our money and innovating for the future. To deliver the strategic objectives, the trust developed specific organisational deliverables for 2019-2020. Each of the organisational deliverables has a single responsible owner, a trajectory for delivery and key performance indicators. The trust's strategy was underpinned by several supporting strategies that were created at a trust, divisional or departmental level. For instance, the organisation development and leadership strategy (2018-2021), quality improvement strategy (2018-2020) and engagement strategies for stakeholders, staff and patients. The trust also had clinical divisional strategies and issue specific strategies, such as the dementia strategy (2014-2019), the learning disability strategy (2019-2021), and the pharmacy strategy (2019-2021). These aligned to the trust's overarching strategy although not all divisions had strategies. The trust's strategy was revised following the announcement that the trust will receive government funding to develop their plans for the Health Infrastructure Plan (HIP2). The trust's strategies drove its governance as they provided a clear structure for meetings and helped to establish which papers needed to be considered at the board.

The organisation development and leadership strategy, 'defining and shaping our culture, developing outstanding leaders', outlined key outcomes and measures of success. This strategy was in the director of people's portfolio. This reflected a strategy which was not only aspirational but also focused on delivering real change and outcomes which improve patient care. These aims took account of national and local key drivers referring to the national framework, 'developing people- improving care' and the National Advisory Group's publication into leadership behaviours. The board meeting minutes for October 2019 showed there was progress in some workforce indicators such as compliance to appraisal, statutory and mandatory training was at an all-time high. In addition, for the ninth month in a row the number of starters to the trust exceeded levers. However, there were still 300 nursing vacancies trust wide which was being managed using bank and agency staff and international recruitment.

The trust embedded its vision, values and strategy in corporate information received by staff. The trust had a set of core values which together spelt CARE these were; Compassion, Accountable, Respect and Encouraging. During the core service inspections, we saw posters throughout the hospital sites displaying the trust's vision and values. Most staff were aware of the trust's vision and core values. The trust created a dashboard to monitor delivery of the strategic objectives against the milestone plan each month. Performance against deliverables are shared with staff at monthly 'In Touch' meetings. At divisional level, the deliverables are discussed at divisional performance reviews each month and any issues are identified for escalation to the executive team. In 2019, the trust launched a new appraisal system whereby staff members have their personal objectives matched to the organisational objectives and these are then monitored through one to one meetings and yearly appraisals.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. The trust measured progress against the delivery of the strategy through a formal dashboard which was delivered through the chief executive report. This enabled the organisation to be held to account and the board to have oversight of progression. The director of strategy and partnerships also reported regularly to the board about the trust's progress against the clinical strategy in their quarterly updates.

Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. Following a review of the strategy and strategic objectives, the trust decided to adopt a deployment approach which engaged with key partners and staff to ensure there were clear lines of accountability and associated measures to each team and individual, support for using quality improvement and innovation methodology and organisational development support for change management.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The trust's first strategic objective was its clinical strategy, 'outstanding care for our patients'. This focused on the NHS Long Term Plan to deliver integrated services to provide a single, connected 'episode' of care with a reformed workforce model and greater use of digital and new technology. The plan also includes an ambition to develop a more closely aligned management structure combining providers and commissioners into local Integrated Care Systems. The trust's clinical strategy was in alignment with the Hampshire and Isle of Wight Health and Care System Sustainability and Transformation Plan (STP). This plan aimed to transform outcomes, improve satisfaction of patients and communities and deliver financial sustainability. The director of strategy and partnerships, who was appointed in 2018, worked closely with system partners and reported there was an appetite to do something different. However, some senior staff felt that the trust had become less focused on matters concerning the here and now in its desire and push for a new hospital.

Following the development of the clinical strategy, two projects were launched. The first was the Transforming Emergency Care Collaborative which was a system wide programme to support the provision of emergency care. The second was a review of Orthopaedic services across the three hospitals. During our core service inspections, we saw there was considerable progress made against these projects. The transformation of emergency care saw an investment in the estates which created mental health assessment rooms, a paediatric area, a rapid assessment and treatment area and a same day emergency care unit. These had improved patient outcomes and flow within the emergency departments. The reconfiguration of trauma and orthopaedic services was completed on time in December 2019 and meant trauma work was concentrated on the Basingstoke site and elective work increased at Winchester. The new model of care had improved to better than national average the 30-day mortality rate for patients with fractured neck of femur.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt respected, supported and valued. Staff of all levels across the trust reported that the trust's culture had improved since our last inspection. Most staff we spoke to during the core

service inspections stated they were proud to work for the trust and felt they were supported to be the best they could be.

In the 2018 Staff Survey, staff reported concerns with line manager capability in relation to lack of up to date appraisals and reported they needed more communication from their own managers and senior managers on trust strategy, operational issues and opportunities to be involved in improvement work. Objective two, 'Empowered Power' in the trust's strategy emphasised, 'investing in our staff, teams and individuals- supporting them to be the best'. One element of the objective was that the trust would design leadership and people management development pathway for managers and leaders. This included the launch of a manager toolkit which aimed to ensure all managers are trained in common HR processes, undertaking appraisals and application of HR policies.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The freedom to speak up guardian had been in post for two and a half years. He had received training from the National Guardian's Office and attended regular guardian's meetings. The guardian role was supported by the board and by a network of eight freedom to speak up advocates who met monthly. The director of people also attended this meeting. From our interviews, we were told the group looked at data to establish patterns, hot spots, areas with radio silence as well as actions to take.

The chief executive office confirmed the guardians did not have dedicated time for this role and upon recruitment their line managers were asked to give them time to do the job. We were told many guardians did not work shift work and therefore could speak to the executive team when issues arose. All guardians had access to debriefings and could access psychological support via NHS Health at Work. Channels for speaking up were advertised on the trust intranet and posters throughout the trust.

The guardian was able to provide examples of how their work had initiated change within the trust. For instance, they were able to describe how a concern raised through the guardian about poor people management skills lead to the enrolment on a training programme for all corporate staff. The guardian told us the top three themes were; behavioural/relationships, bullying and harassment, systems and processes. The guardians took part in 'Staff Focus Week' by attending walk-rounds to meet staff and raise their profile.

Raising concerns including whistleblowing and freedom to speak up came under the chief nurse's portfolio. The guardian met regularly with the CEO and reported to the board quarterly. The chief nurse took responsibility for triangulating information from different speak up methods and ensured data was not duplicated.

Staff could also raise concerns through the speak in confidence as well as the normal line management and incident reporting framework. Speak in confidence was a system whereby staff could raise issues anonymously through a web-based tool. On submission, the executive team were notified and could response electronically to the alerter without them having to identify themselves.

The trust took appropriate learning and action as a result of concerns raised. The chief executive officer was able to provide examples of how concerns raised led to a change of practice within the trust. For instance, one suggestion was to use a different piece of equipment which, following discussions with procurement, saved that unit seven thousand pounds. Another highlighted the expectation of night staff washing patients in the early hours of the morning before the day staff

began their shift. This practice was stopped immediately and communicated through the clinical matrons.

The November 2019 board papers showed between January and October 2019, there were:

- One whistleblowing case
- 46 freedom to speak up cases
- 50 speak in confidence cases

The trust's organisational development and leadership strategy had at its core a cultural change programme delivered in line with the NHS Toolkit- Creating a culture of compassionate and inclusive leadership. The three-year programme was launched in 2018 and consisted of three phases: discover, design and deliver. Fifteen change ambassadors were recruited for Phase One which involved an extensive internal review, including a cultural audit. This led to the development of recommendations based on four themes- staff development, creating the right culture, communication and planning for the future. The findings from the phase one was presented and endorsed by the board in June 2019. Twelve new ambassadors were recruited to carrying forward recommendations in phase two which launched in September 2019.

All staff had the opportunity to discuss their learning and career development needs at appraisal. The trust launched a new appraisal process for all staff (accept doctors). The process included a wellbeing wheel, focus on values and behaviours and career conversations. These aimed to facilitate staff focused developmental appraisal conversation. In October 2019, the appraisal compliance rate was 84%, this was below the trust target of 90%, however this was a continuation of an upward trend. Some departments had maintained a 100% compliance, and the trust maintained everyone's focus on appraisals through a communication campaign and through divisional meetings.

The trust recognised staff success by staff awards and through feedback. The trust launched the WOW! Awards which are a national award system that recognise outstanding customer service. Staff can be nominated for an award by their colleagues, patients or visitors, with a handful of winners selected by the trust's public governors each month.

In response to the 2018 staff survey, the surgical division planned to introduce 'you're amazing' mugs which acted as local WOW! Awards.

The trust held its first 'Respect' event in June 2019 which focused on 'I am a person not a Band'. Staff looked at how staff of different grades and staff groups relate to and treat each other. The event included interactive workshops with actors who played the roles of staff in anonymised scenarios based on events which had taken place in HHFT. The trust held a 'Inclusivity' conference in December 2019 which included a guest speaker from NHS Employee.

The trust applied Duty of Candour appropriately. The trust had a Duty of Candour policy which outlined steps staff should take in identifying and reporting notifiable patient safety incidents as well as the steps to be followed to deliver the Duty of Candour. Staff could access training through the online learning system and all staff at the core service inspection were able to describe the Duty of Candour and their responsibility in relation to it.

Within the risk management software used for incident reporting, there was a section on the incident report form for staff to detail the steps taken under the Duty of Candour. The 48-hour incident review panel and the trust's serious event review group all had a role to ensure the Duty of Candour was undertaken. The Chief Nurse was responsible for monitoring compliance to the

Duty of Candour and compliance was reported in the quarterly quality report to the trust's quality and performance committee. The report for January 2020, showed in 2019 there had been no incidents where the Duty of Candour was not met in line with the trust's policy. In addition, the trust undertook audits to assess compliance.

Managers addressed poor staff performance where needed. Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. We saw that between October 2018 and September 2019, 16 members of staff including band 2 through band 8 had been suspended or moved wards after disciplinary reviews.

We were given examples of the medical director addressing concerns around behaviours and professional standards. We heard that a clear message was being delivered to all staff to say what was once tolerated won't be anymore. Where behaviours did not change, interventions were being looked at such as involvement of HR. Staff told us in 2019, the trust launched the manager toolkit which provided a HR induction for senior managers to empower them to deal with challenging behaviours in line with HR policies. This was being rolled out for all band 6 staff.

The guardian of safe working hours had worked in this role since October 2016. She sat independently from the management structure and represented and resolved issues related to working hours for junior doctors. The guardian of safe working hours reported an increase in exception reporting (reports raised by junior doctors when their actual work has varied from their agreed work schedule) from 80 a month to appropriately 300 a month. She felt this was due to a shift in culture, whereby junior doctors believed in the process. However, there was no protected time for this role and limited admin support due to maternity leave.

Staff Diversity

The trust provided the following breakdown of staff groups by ethnic group.

Ethnic group	Medical and dental staff (%)	Qualified nursing and midwifery staff (%)	Allied health professionals (%)
White - British	49.7%	58.3%	71.0%
White - Irish	1.7%	1.2%	1.4%
White - Any other White background	5.3%	3.0%	4.3%
White Greek	0.7%	N/A	0.6%
White Other European	N/A	1.5%	N/A
Mixed – White & Black Caribbean	0.5%	0.1%	0.3%
Mixed - White & Black African	N/A	0.1%	N/A
Mixed - White & Asian	0.9%	0.1%	0.3%
Mixed - Any other mixed background	1.0%	0.6%	N/A
Asian or Asian British - Indian	8.0%	4.6%	3.5%
Asian or Asian British - Pakistani	1.8%	0.1%	0.3%
Asian or Asian British - Bangladeshi	0.5%	0.1%	N/A

Asian or Asian British - Any other Asian background	4.0%	2.5%	0.9%
Asian Mixed	N/A	0.3%	N/A
Asian British	0.3%	0.6%	N/A
Asian Unspecified	0.3%	0.3%	N/A
Black or Black British - Caribbean	0.1%	0.4%	1.2%
Black or Black British - African	1.8%	3.1%	3.2%
Black or Black British - Any other Black background	0.1%	2.3%	N/A
Chinese	1.6%	0.3%	0.3%
Any Other Ethnic Group	3.5%	1.7%	0.6%
Filipino	0.2%	5.4%	0.6%
Undefined	6.1%	3.2%	3.2%
Not Stated	10.0%	12.2%	8.4%

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

Staff networks were in place promoting the diversity of staff. The trust launched its first staff Inclusivity Network in 2018, which was aimed at improving and promoting an inclusive culture within the trust. The network met monthly and is formed of clinical and non-clinical representation. The trust's equality and diversity managers told us how the membership of inclusivity network had grown and that there was now representation across sites and all roles. The network is accountable to the workforce subcommittee and has several sub-working groups that bring people from across the Trust and beyond together to work on projects and initiatives to promote equality. These groups were the Black and Minority Ethnic (BME) champions groups, the Lesbian, Gay, Bisexual, Trans and other sexual and gender minorities (LGBT+) champions groups, the international champions groups and the disability champions groups. All staff could join the network and champions groups, who all have key objectives.

The trust marked Black History Month in October 2019 through a series of activities lead by the inclusivity network and the BME champions group. One activity involved a display of life stories taken from BME staff, from all levels throughout the Trust, which were shared through social media, blogs and display boards, telling their stories of working in the NHS. The trust also served a range of meals from around the world (Africa, India, Nepal and the Caribbean) to patients, staff and visitors throughout the month. Eleven members of staff attended the Royal College of Nursing's Black History Month event which recognised the contribution of BAME staff in health and social care. At the event, the trust's BME Champions received an award for their contribution towards promoting and advancing equality, diversity and inclusion and the experiences of BME patients and colleagues.

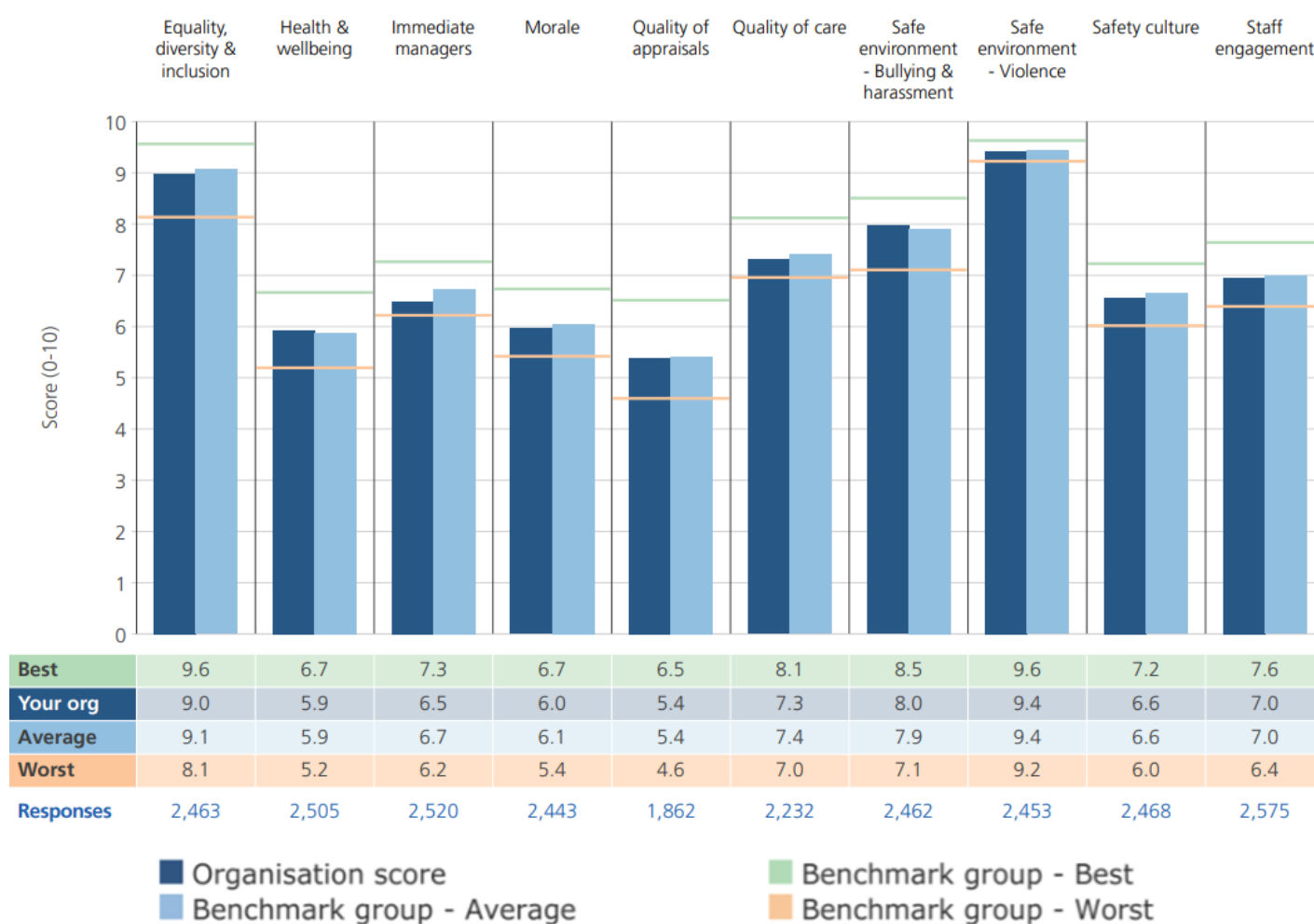
In 2019, the trust held two workshops linked to the LGBT+ month. One workshop involved a patient speaking to staff about their positive experience of gender transition, which helped staff to understand the process. Staff told us as part of a workshop, guidance on how to talk about sexual orientation and gender identity was shared with staff to help make conversations easier and more comfortable. This guidance was readily available on the trust's intranet for staff who were unable to attend the workshop or for staff wanting to refamiliarise themselves.

The trust received over 800 staff commitments outlining their support for the LGBT+ community. Those who submitted a commitment received an NHS rainbow badge.

As part of the trust's recovery plan to fill its 300 nursing vacancies, following a change in its baseline numbers and expansion of services, it had undertaken a large international recruitment campaign. At the time of the inspection, the trust had recruited 83 international nurses and planned to recruit eight cohorts of international nurses each holding 24 nurses this year. This meant the trust would have an international workforce of 131 nurses by April 2020. The trust had set up a champions group for its international workforce. The trust arranged for the nurses to arrive as a cohort, assisted with settling in the area and provided local accommodation. The nurses spent time shadowing and engaging with the clinical matron and band 7 nurses. The trust used a buddy scheme for ward nurses. We were told the trust engaged with the STP nurse supply board who had an international recruitment of nurses workstream. Best practice and learning were shared at this forum.

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



There were no themes in the 2018 report that were significantly higher (better) when compared to the 2017 survey.

The trust's 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Equality diversity and inclusion
- Health and wellbeing
- Immediate managers
- Quality of care
- Safe environment – bullying and harassment
- Safety culture
- Staff engagement

(Source: NHS Staff Survey 2018)

Historically, the equality and diversity and the health and wellbeing steering groups were joint. In 2018, the decision was made to separate the groups. Staff told us this had resulted in more traction and better engagement with the whole organisation.

The trust had developed three nursing forums. The clinical matron forum met on the first Wednesday of each month. The band 7 forum met the first Thursday of each month and the band 6 forum met on the last Wednesday of each month. The equality managers chaired the forums and told us the forums gave senior staff an opportunity to receive training and to share information and best practice with their peers. It improved working relationships as it brought together groups of staff who would not normally socialise but shared similar dilemmas and mindsets. The trust used a ticketed approach for the forums on a first come, first serve basis. The forums were open to everyone; not just clinical staff.

The trust had embedded Schwartz rounds across all three sites since our last inspection. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim of a Schwartz Round is to offer staff a safe environment in which to share their stories and offer support to one another. Staff told us these were well attended by a mixture of staff disciplines. There were plans for the inclusivity network to be given protected time to facilitate a Schwartz round.

Generally, staff felt valued and included in the trust's vision. The Director of People told us the transformation of trauma and orthopaedics helped to bring teams together. At first there was much debate and staff were vocal about their concerns, however following multiple consultations and communications, most staff supported the process. Some roles were realigned and those staff who did not wish to change sites were re-deployed. No staff left the organisation because of the transformation and staff reported on our core service inspection that they felt involved and listened to.

The chairman presented a board charter to the board in January 2020. The charter was developed following a board development workshop whereby members reviewed the role of the board and its workings. The work also considered work feedback from the culture change programme. The charter established three roles of the board and ways of working which reflected the trust's values.

Workforce race equality standard

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

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

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

Notes relating to the scores:

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

WRES Indicators from ESR (HR data) ^(*)		BME Staff		White Staff	Are there statistically significant difference between...			
					BME and White staff?	Last year and this year? (BME staff)		
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+		2.7%		4.8%		0.5%		
1b. Proportion of non-clinical staff in senior roles, band 8+		2.4%		8.3%		1.0%		
2. Proportions of shortlisted candidates being appointed to positions		15.7%		19.4%		4.1%		
3. Proportion of staff entering formal disciplinary processes		1.3%		0.4%		0.5%		
4. Proportion of staff accessing non-mandatory training and CPD		58.6%		52.2%	Not assessed			
WRES Indicators from the NHS staff survey ^(**)		Proportion of respondents answering "Yes"			Are there significant differences between...			
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)	
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	25.3%	23.5%	23.6%			1.1%	
	Peer group	29.9%	27.9%	28.7%				
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	26.7%	28.4%	28.6%			2.2%	
	Peer group	30.1%	26.0%	27.0%				
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	71.0%	85.4%	83.1%			-9.0%	
	Peer group	69.8%	86.3%	83.3%				
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	19.8%	7.5%	9.7%			5.6%	
	Peer group	15.9%	6.7%	8.5%				
Trust staffing numbers ^(*)		2018				2017		
9. [BME Voting Board Members] and Board compared to overall staff demographic		[0]			[0]			

Key

- Statistically significant or negative finding
- Not statistically significant
- Positive finding
- Statistical analysis not undertaken as less than 30 BME staff responded
- ⬆ Statistically significant improvement
- ➡ No statistically significant change
- ⬇ Statistically significant deterioration

As of March 2019, four of the ESR staffing indicators shown above (indicators 1a to 3) showed a statistically significant difference in score between white and BME staff:

- 1a. In 2018, BME candidates were significantly less likely than white candidates to hold senior (band 8+) clinical roles (2.7% of BME staff compared to 4.8% of white staff). This was not significantly different to the previous year, 2017.
- 1b. In 2018, BME candidates were significantly less likely than white candidates to hold senior (band 8+) non-clinical roles (2.4% of BME staff compared to 8.3% of white staff). This was not significantly different to the previous year, 2017.
2. In 2018, BME candidates were significantly less likely than white candidates to get jobs for which they had been shortlisted (15.7% of BME staff compared to 19.4% of white staff). This figure was an improvement on the 2017 staff survey by 4.1%.
3. In 2018, BME candidates were significantly more likely to enter formal disciplinary processes than white staff (1.3% of BME staff compared to 0.4% of white staff). This was not significantly different to the previous year, 2017.

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

7. 71.0% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 85.4% of white staff. This was not significantly different to the previous year, 2017.
8. 19.8% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey) which was significantly higher when compared to 7.5% of white staff. This was not significantly different to the previous year, 2017.

There were no BME voting board members at the trust either in 2018 or 2017.

(Source: NHS Staff Survey 2018; NHS England)

The senior leadership team recognised that BME staff did not have an equivalent working experience to non-BME staff and were working to address this. The equality and diversity managers told us they presented WRES data to the board which did not only provide a channel for feedback between the inclusivity network and the board, but also ensured actions are reflective of the staff voice. The inclusivity network oversaw the trust's WRES action plan which had seven actions, each with a responsible lead and timescale.

NHS England and NHS Improvement published a guide called 'A Model Employer' to help NHS organisations set its own target for BME representation and increase the recruitment of BME staff at senior levels. We saw this was discussed at the workforce and organisational development committee in November 2019. Members discussed the trust's approach, ideas included having one BME staff member on the shortlisting or interview panel and reverse mentoring where band 5 BME staff or under can mentor a board member. This fed into the cultural change programme.

Likewise, starting in August 2019, all NHS organisations were required to publish a report on the work experience of staff with a disability for the first time under Workplace Disability Equality Standard (WDES). Data collected by the trust for the WDES reflected that disabled staff had a poorer work experience than non-disabled staff. The trust had created a WDES action plan that addressed a variety of issues for instance, to promote leadership, training and development options to employees with disabilities via the disability champions group.

Likewise, the trust had identified challenges that created or supported the gender pay gap within the trust. At the time of our inspection, the trust had not yet taken actions that have impacted this inequity, but staff told us there was plans for this to be discussed at the inclusivity network meeting in March.

Friends and Family test

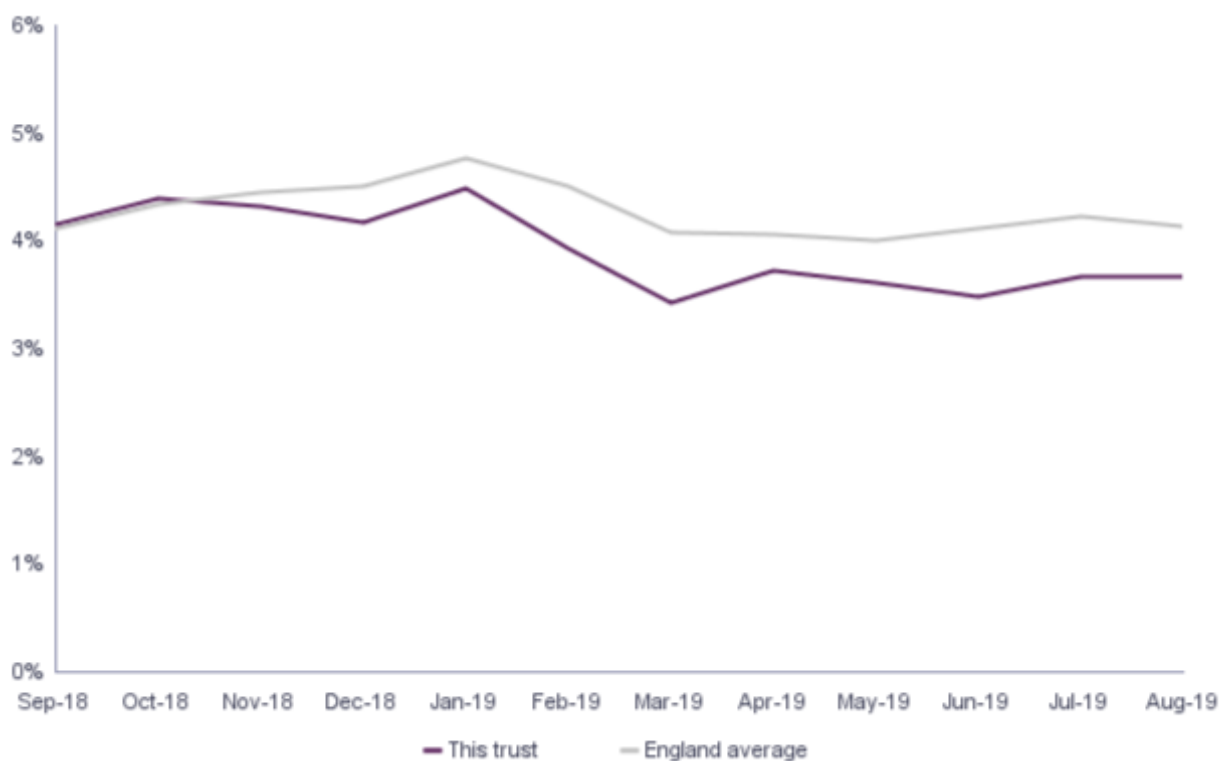
The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 95.4% and 96.9% between November 2017 and October 2019. The data appeared to be stable with only random variation over the whole period.

(Source: Friends and family test)

Sickness absence rates

The trust's sickness absence levels from November 2018 to August 2019 were below the England average.



(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2019 General Medical Council Survey the trust performed as expected on all of the indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance

There was a new governance structure in place and the board of directors recognised further work was required to strengthen and embed processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust's governance and performance management process had changed since our 2018 inspection. Previously, there were clinical matrons who reported to their divisional medical director. Now each divisional management team was a triumvirate with nursing, medical and operations directors. The executive team felt this had increased the nursing voice at board level and had aided with developing clear priorities for each division. However, some staff during the core service inspection still reported a disconnect between ward and board. Some staff also reported it was not always clear who was best placed to speak to as there had been so many changes within the leadership team and their portfolios.

There were clinical directors for each /speciality who reported to their divisional medical director. The divisional medical directors met with the chief medical officer weekly, although divisional medical directors were line managed by the chief executive officer.

There were operation directors for each business unit who reported to their divisional operations director. The divisional operations directors met with the chief operating officer who was also their line manager weekly to discuss operations with a focus on referral to treatment times and cancer targets.

There were clinical matrons for each speciality who reported to their divisional nursing director. The divisional nursing directors met with the chief nurse, who was also their line manager.

The addition of senior management for each division was anchoring the change of leadership by gathering and consolidating information so that risks across the piece were reviewed and escalated to the executives if required. Thus, improving oversight and assurance of the board.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. The trust's governance and performance management processes had changed our last inspection. The chairman implemented a new committee system following an annual year in January 2019. This had improved the reporting lines between committees but not all committees dovetailed. All staff reported the new structures provided clear channels of communication and oversight. One member of the executive team told us they felt able to be vulnerable during governance meetings by admitting they needed further explanation or clarification to gain better understanding of the information presented.

The chairman told us he had changed the format of the board meetings and the location to alternate between sites to engage with more staff. The trust board met monthly and meetings were held in two parts, the first being in public and the second being private. Public board meetings begun with a presentation from clinical teams who either presented a patient story, a staff story or highlighted a clinical pathway to improve patient safety or experience. The presentations provided an opportunity to learn from real life experiences which enabled the board to gain an insight into an issue from a patient or staff's perspective and helped to triangulate issues.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. The trust published the papers and minutes for the public board meeting on their website. The papers for the quality and performance committee did contain relevant

information but were very lengthy (469 pages in January). The chairs told us the committee used to be performance only, but quality was added as it was felt the two went hand in hand. In response, the length of the meeting was increased to 2 and a half hours. The chairs reported the divisions used to produce streamlined reports based on data which was a month out of date and was accompanied with very little explanation. It was felt this was still a work in progress, but the committee were cautious to ask for less information yet as it had taken time for the divisions to be more open.

The quality of the board meeting minutes had improved since our last inspection. There were summaries of discussions, rationale for decisions and records of challenge. This meant anyone who could not attend the meeting could understand what took place.

The board had a committee system which ensured the appropriate issues, information and concerns were escalated to the board. There were seven committees that reported to the board: quality and performance (new), nomination, remuneration, finance and investment (new), workforce and organisational development (new), risk and audit. Some of the committees were still reasonably new at the time of our inspection and were still developing some aspects of their assurance and reporting processes. Twelve subcommittees fed into the quality and performance committee including, but not limited to serious incident review group, patient safety effective experience group, mortality surveillance group and the mental health committee. One sub-committee fed into the finance and infrastructure committee called the capital committee.

Non-executive and executive directors were clear about their areas of responsibility. The new committees, as indicated above, had been in operation for nine to twelve months and had completed their first yearly effectiveness self-assessment. The pre-existing committees had conducted their regular yearly effectiveness self-assessment. All sub committees had reviewed the outcomes of their self-assessments and the outcomes were presented in the January public board meeting. All committees agreed that the committee's business covered matters of importance relevant to its terms of reference and most committees felt all members behaved professionally, the committee's purpose was clear, and the frequency of meetings were appropriate. However, there were themes for improvement amongst the committees in relation to updating terms of reference, enough time being given to each item to enable debate and decision making, and timeliness of papers/level of information the committee receives.

The quality and performance committee were responsible for overseeing the safety of the care provided to patients. Since our last inspection, the chairman had changed to a non-executive director, rather than an executive director and membership now included two clinical medical directors. We observed the quality and performance committee meeting held on 24 January 2020. We observed detailed conversations where both executive and non-executive members were engaged in discussion and there were high levels of challenge. As part of the standing items, the committee discussed its action tracker, performance scorecard and risk register. The chairperson asked all presenters what kept them awake at night, this helped to keep the committee sighted on areas of concern.

The trust had a well-developed governance system for medicines. Pharmacy leaders were present or represented at all relevant meetings and committees where matters addressing medicines use in the trust were discussed. The pharmacy senior management team felt they were raising the profile of pharmacy through presenting to executives, non-executives and commissioners. The chief pharmacy told us the pharmacy senior management team were much quicker at picking up and responding to issues and team members know who to talk to if they have an issue or concern. However, during the core service inspections we found some wards where the storage of

medicines was an issue. We were told due to vacancies within pharmacy, not all wards had a dedicated pharmacist.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. Safety and quality data were discussed at monthly ward and departmental meetings from the information provided by the divisional performance scorecard (DPS) and the local key performance indicator scorecards which included reviews of local incidents, investigations, complaints, audits and other operational and quality issues. The scorecards were displayed in staff areas to improve staff accessibility and encourage feedback.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. Information from the monthly ward and departmental meetings were taken to the business unit governance meetings for wider discussion, debate and benchmarking. This meeting also helped to prepare for presentation at monthly divisional performance reviews and escalation into divisional senior management team meetings, divisional quality committee and or divisional board.

Recruitment processes were not robust for trust staff. We reviewed nine staff files for a range of professionals and grades including nurses and doctors. We checked for evidence of completed recruitment processes such as interview notes, references, occupational health and DBS checks. We found two files did not contain evidence of interview notes, two staff had no references and one staff had only one reference which was from a close friend, one had no occupational health clearance and one staff member started employment two weeks before occupational health clearance, and one file did not have evidence of a DBS check. In addition, two files showed the staff members' probation was extended but the rationale and sign off for this was not clear and one staff member was not on the specialist register and should be given their role within the trust.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The trust employed a Mental Health Act manager who monitored compliance with the act and undertook bespoke staff training. The trust established a mental health and mental capacity committee in April 2018. The committee met every other month and was chaired by the chief nurse. We saw there was a robust reporting structure as the committee fed into the quality and performance committee who escalated concerns to the board. This meant the board was sighted on concerns within the mental health service.

A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements. There were service specification and service level agreement between the trust and a mental health NHS trust. The trust had employed a liaison team on honorary contracts. The team consisted of consultant psychiatrists, a band 8 nurse manager, one team leader band 7, an older person's mental health clinical specialist and band 6 nurses. The team conducted specialist assessments across the trust, followed up patients at risk, deliver staff training and provided a 24-hour urgent assessment service to the emergency departments.

Board Assurance Framework

Trusts are required to provide effective and comprehensive processes to identify, understand, monitor and address current and future risks. The board assurance framework (BAF) is a method of setting out the most important risks facing the organisation. It sets out the control framework

used to manage them, any gaps in control and how the organisation satisfies itself that the controls are working as intended.

The trust provided their Board Assurance Framework (BAF), which details the below four strategic objectives:

1. Outstanding care for our patients
2. Empowered people
3. Living within our money
4. Innovating for the future

(Source: Trust Board Assurance Framework – September 2019)

The board had redeveloped its BAF so it aligned to the trust's strategy which was approved in 2018 and spanned over four years. The trust provided us with their BAF as of 2 March 2020. The BAF confirmed the most significant risks in the delivery of the trust's strategic objectives which were clearly defined.

The BAF was easy to interpret and included an overview page which collaborated the strategic objectives, the risk owner and the displayed the associated risk ratings. The BAF used differing and complementary approaches to presenting complex and detailed information to aid interpretation such as visuals and trajectories. This made it accessible to other staff including the non-executive directors and divisional directors.

There was a clear and consistent approach in categorising risk using a standardised matrix of impact vs likelihood. Each of the nine risks had a risk score before the application of controls (gross risk), after the application of controls (net risk) and a target risk score. The scores helped the trust to assess what risks required action and what risks were mitigated through current controls.

A clear assurance mapping process was undertaken for each risk. This identified the key sources of assurance for each of the controls used to inform board members of the effectiveness of how risks are managed or mitigated. For example, the assurance of controls for the financial risk included internal and external audits, financial and performance reports and benchmarking.

The contribution of which existing controls have in mitigating the risk is demonstrated by the difference between gross and net risk scores, however, where there were big differences the trust had identified few sources of assurance and did not contain the level of detail needed for the board to demonstrate their assurance.

The BAF explicitly stated the risk appetite of the board which was bespoke to specific issues. For example, the board had a low appetite for risks relating to patient safety or patient outcomes. The target risk scores varied and related to the trust's appetite for risk.

The BAF was transparent in identifying the assurance committee who provided oversight of each risk and who is responsible for specific mitigating actions and in what time frame. For example, the finance and investment committee had oversight of the financial risk and the action owner for this was the chief nurse and chief finance officer.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Trust corporate risk register

The trust provided a document detailing their highest profile risks. Each of these has a current risk score of 16 or higher, which mean they have a high likelihood of occurring and also will have a high impact.

ID	Description	Risk score (current)	Risk level (target)	Last review date
1.1	If we fail to meet the requirement of our licence/constitutional standards, then we will not be delivering safe and effective care to our patients.	16	12	September 2019
1.2	If we do not maintain and develop our major capital assets (estate, medical and non-medical equipment) then there may be unacceptable clinical, regulatory and financial consequences.	16	12	September 2019
2.2	If we fail to recruit and retain an adequate and skilled workforce, then this will result in the inability to provide safe care and deliver constitutional needs.	16	9	September 2019
3.1	If we do not achieve our cost improvement and productivity plans, then we will be unable to achieve financial stability.	20	6	September 2019
3.2	If we do not meet quarterly financial control targets, then the trust will lose Provider Sustainability Fund (PSF) (maximum risk 2019/20 £7.7m).	16	5	September 2019

(Source: Board assurance framework)

Arrangements for identifying, recording and managing risks, issues and mitigating actions required embedding. The trust was on a journey of improvement regarding its risk management processes. This included a new BAF document drafted in September 2019 which focused more on strategic risks. The board was making significant changes to the way in which risks were assessed and reported. The board approved a new risk appetite in October 2019 which outlined the amount of risk the trust is prepared to accept, tolerate or be exposed to at any point in time to deliver its strategic objectives.

A proposal to change the trust committee structure to introduce a sub group called the executive risk management group was presented and adopted by the board in December 2019. It was felt, following the revised board subcommittee structure, there was potential for overlap between the different committees and that the trust should build upon their collaborative work with NHS Improvement in relation to risk management delivery and reporting. The purpose of this sub-group

was to oversee the delivery of the trust's risk management framework and review the trust BAF and trust register to ensure appropriate delivery of risk management. The chief executive officer chaired the group who met monthly. At the time of our inspection, the new executive risk management group had only met once so it was too soon to assess the effectiveness of this group in risk management.

Recorded risks were aligned with what staff said were on their 'worry list'. The senior leadership team understood the top risks to the organisation as stated in the BAF document. These reflected the risks expressed by frontline staff during the core service inspection. These were staffing, estates and finances.

Senior leaders had recognised an urgent need to review the 670 risks on the trust risk register to ensure they were relevant and suitably mitigated. Some of these risks had been on the register for years without review. The trust was in the process of mapping the risks against the new risk appetite. This work had led to archiving 170 red and amber rated risks due to duplication, not meeting the criteria or the risk no longer existed. Each of the remaining red and amber risks were mapped to a board committee for further discussion. However, the review was not complete, and more work was required to ensure all risks were reflective of current concerns. Senior staff told us following workshops and training for senior managers, divisions bought into the programme well, but the process was still in its infancy and needed embedding.

In November 2019, the trust undertook an internal audit into its risk management processes which found the trust's tone and culture to risk management was becoming more consistent and coherent from the board, with the new committees carrying out 'deep dives' into particular risks. This formed one of the clinical strategic objectives for 2019/20 which was to carry out a rolling programme of deep dives into each speciality. However, historically the deep dives were not scheduled to gain assurance in relation to specific risks on the BAF or risk register.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Senior staff told us there was misunderstanding within the divisions about risk management processes and how to articulate risks. To resolve this, workshops for the board and senior management team took place in October and November 2019 to discuss best practice. There were plans for senior managers to receive risk management training. On a quarterly basis the divisions presented their risks to the risk committee. During our core service inspection, we saw all divisions maintained and reviewed their own risk registers regularly. Senior staff were able to tell us what the top risks were to their department.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The trust used an integrated performance report to summarise the trust's key metrics. There were scorecards for quality, performance, HR and finance which were colour coded; red, amber or green to demonstrate whether trust was meeting or not meeting the metrics. Detailed discussions on each area occurred within the relevant board sub-committees (finance and investment committee, workforce committee and the quality and performance committee) and fed back up to the board via the relevant chairman's report.

The quality and performance committee reviewed the quarterly quality account report which highlighted areas of good performance and areas of concern for escalation to the board. The quarter three report showed the trust continually exceeded its cancer targets, except for 62 day waits for first treatment (from urgent GP referral) which had a compliance rate of 83.4% against a target of 85% in quarter three. Most breaches were within urology and an extensive work

programme was in place to improve processes and accelerate diagnostic tests within the urology pathway. Meeting cancer targets was one of the trust's clinical strategic objectives for 2019/20.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. The trust had a systematic programme of clinical and internal audit to monitor quality, operational and financial processes and systems to identify where action should be taken. The trust had an audit program that included audits at divisional, and provider level. The trust had changed the way in which internal audits were reviewed, from September 2019, the relevant sub committees would review internal audit reports before their consideration at audit committee. This enabled scrutiny and approval of the management responses and suggested actions by the appropriate subcommittee.

The trust submitted information for national audits. A national audit report including outcomes went to the Patient Safety, Effectiveness and Experience Group (PSEEG) following discussions at divisional governance meetings. The PSEEG reviewed the report with the divisional leads in attendance. The trust had decided to form a clinical effectiveness group who would analyse the outcomes further.

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity. The trust had an incident response plan which was approved in July 2018. It stated the trust's incident command team would direct the trust's response to any major incident. Ensuring these plans' readiness was essential, and the trust tested those plans internally and with partners by conducting desk-top and other exercises.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers did not monitor changes for potential impact on quality and sustainability as there was no process to review implementation of business cases. When considering developments to services or efficiency changes, quality and sustainability was assessed and monitored. All evidence we reviewed reflected that financial pressures did not compromise care at the trust. When changes were made requiring funding, a lead needed to submit a business case for review and approval. Each proposal included a quality impact statement. Business cases would be reviewed by the trust senior management team which would make recommendations to the finance and investment committee. That committee then made recommendations to the board where the proposal exceeded the committee's delegated authority. Where relevant, other committees would review business cases. We saw each proposal included a quality impact assessment. However, we were advised that the trust does not currently have a structured process for undertaking post implementation reviews of business cases.

Never Events/Serious Incidents

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 2018 and October 2019, there were five never events reported by the trust. These were categorised as wrong site surgery (2), wrong implant/prosthesis, overdose of methotrexate for non-cancer treatment and unintentional connection of a patient requiring oxygen to an air flowmeter.

Between October 2018 and September 2019, there were 98 serious incidents (SI) at the trust. The most common incident types were slips, trips and falls (29%), pressure ulcer (18%) and maternity or obstetric involving baby only (13%).

All SIs were reviewed at the trust's serious event review group (SERG) and patient safety incidents were analysed in a quarterly quality report reviewed by the quality and performance committee. Through this process the trust had identified key themes such as poor documentation of falls and pressure ulcers, care of the deteriorating patient, medication errors relating to diabetes, WHO checklist issues and delayed or missed diagnosis.

The SERG had delegated authority to its sub-groups, the falls prevention group and the pressure ulcer steering group, to review the investigations for fall and pressure ulcer incidents resulting in moderate or severe harm. We saw the first edition of the learning from events trust wide newsletter (December 2019) which focused on learning from incidents and complaints. It contained learning from a never event involving connection to an air flowmeter rather than oxygen and a review of the work being undertaken to reduce falls which included new falls training, electronic post falls documentation including the hot debrief and the introduction of a quarterly falls newsletter.

The trust also had several governance committees who also reviewed incidents and learning from SIs such as the medication error review group, reducing harm from deterioration and mortality surveillance group.

The private monthly board papers included details of SIs reviewed and discussed at the trust's serious event review group in the previous month. There was a summary of the SI, the root causes identified, and actions taken.

Actions and learning were overseen by SERG who produced a shared learning points document which was cascaded via trust communication mechanisms, including the midweek message. Each division also produced shared learning which was available on the intranet to enable shared learning across the trust. The trust established a learning from incidents forum in November 2019 whereby all staff were welcomed to attend and hear the learning from two incidents monthly.

At the last inspection, we stated the trust should ensure incident investigations are completed in a timely manner and the patient or family are involved in the setting of terms of reference and are informed of the outcome of the investigation before it is signed off as complete.

At the end of October 2019, the trust had 60 serious incidents requiring investigation (SIRI) cases open, of which 16 had breached the 60-day time frame for investigation. To address this, an extra-ordinary SERG was scheduled. The trust's 48-hour panel met twice weekly to review incidents of moderate and serious harm to consider the level of investigation required, to support the Duty of Candour requirements and SIRI/Never Event declaration. The panel aimed to provide an open forum for the discussion of incidents with staff from across the trust to support a more transparent and consistent approach to incident reporting and the opportunity to ensure immediate actions are taken. We reviewed five serious incident reports/root cause analyses and found overall the reports were comprehensive, were patient focused and the investigation was expertly led.

Safeguarding

Between October 2018 and September 2019, the trust made 2,701 child safeguarding referrals. The trust had a safeguarding children's team who monitored practice through direct involvement in inpatient cases. They also had oversight of child presentations to the emergency departments and minor injuries unit. The team were members of the Hampshire safeguarding Children Partnership.

Between October 2018 and September 2019, the trust made 27 adult safeguarding referrals. The trust had a safeguarding adult's team who were the first point of contact for staff across the trust when they had safeguarding adults concerns and could make referrals as appropriate to adult services. The team were members of Hampshire Safeguarding Adults Board.

Both safeguarding teams provided responsive supervision and advice to staff, undertook audits, reviewed incidents and worked to a continual improvement plan. The trust held a safeguarding children and adults assurance group who used to meet quarterly but a decision was made to meet monthly from February 2020. The group reported quarterly to the quality and performance committee. The safeguarding leads provided quarterly reports via the assurance group to Hampshire CCG and a bi-annual report to Board. The safeguarding leads met regularly with the chief nurse who was the executive lead or safeguarding. The team used the trust's risk management system to report any shortfalls in safeguarding practice. The safeguarding children's and the safeguarding adults teams worked closely together to support learning and individual incidents.

In addition to safeguarding leads, there were safeguarding champions throughout the trust. The champions held a safeguarding forum where staff could bring cases to share and discuss. The group looked at guidelines, made conclusions and shared the meeting minutes afterwards. The safeguarding leads told us this meeting was very well attended.

The trust had not been involved in a serious case review (SCR) or a safeguarding adult review (SAR) within the 12 months prior to this inspection. However, the trust had been involved in two multiagency reviews and we saw the trust had implemented the recommendations made from these reviews to prevent further incidences. For example, the trust had introduced a standard operating procedure for recording new born marks or injuries.

Finances Overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (2017/18)	Last Financial Year (2018/19)	This Financial Year (2019/20)	Next Financial Year (2020/21)
Income	£390.7m	£427.5m	£443.3m	£448.2m
Surplus (deficit)	(£3.8m)	£12.3m	£15.4m	(£8.7m)
Full Costs	£394.5m	£415.2m	£427.9m	£456.8m
Budget (or budget deficit)	£7.9m	£4.3m	£14.8m	£0

The surplus reported in 2018/19 was higher than the previous year. Projections for the next financial year forecast a deficit of £8.7 million for 2020/21.

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

The trust was facing a significant financial challenge in the current financial year which was likely to impact on its future financial sustainability. At the time of our inspection the trust was forecasting that it would not achieve its in-year control total and would end the year with a deficit of £11.09m, a negative variance of circa £23m to its plan (including loss of £5m of central support funding). There were a number of factors behind this position including the fact that the trust had not achieved its cost improvement plan.

Significant risks remained to the trust achieving both its in-year plan and longer-term financial sustainability. Senior management felt the focus on addressing this issue needed to be renewed. The trust needed appropriate governance and clear lines of financial accountability, particularly in relation to the clinical divisions who account for the majority of operational spend, to ensure there was financial 'grip and control'.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Board members understood the risks related to non-clinical aspects of trust infrastructure. For instance, the leadership recognised both the current low level of digital maturity and the challenges with the current state of existing IT systems. Senior leaders told us non-executive directors were very supportive about the trust's need to progress its IT systems, but the executives required further assurance about the value of the changes on the trust. The current systems could be slow, difficult to use and were not standardised across sites. In response to this risk, the trust had developed a comprehensive three-year digital care strategy to develop both the organisation's digital maturity and replace or improve existing digital systems. The trust was working closely with NHS Digital and NHS England. The strategy contributed to the delivery of the four trust strategic objectives and had an overall objective of introducing real time data capture at the point of care, with an enhanced ability to share information between clinicians across the trust and the wider system and with patients. The strategy will be delivered through three workstreams; no more note, agile clinician and without walls. Each workstream had its own steering board who met quarterly and reported to the board every other month. Each workstream also had a working group who met monthly. Clinicians sat on the working groups as the trust recognised digital changes needed to be shaped by the people using the systems daily.

At the time of our inspection, the trust used a mixture of paper and electronic records. As part of the 'No More Notes' workstream, it was in the process of scanning all historic medical records with the plan being to empty the medical records libraries over the next two and a half years. The trust was also developing digitalising paper records so that the trust could migrate from paper forms to electronic forms.

The 'Agile Clinician' work included several major change projects such as the digital recording of all patient observations, supported by equipment voice recognition, the development of digital whiteboards to capture real time information on bed state and patient discharge plans and progress and the development of electronic nursing records. It was felt the digitisation of patient observations would have a huge impact because it eliminates human error in calculating NEWS scores ensuring those patients who are deteriorating are flagged as needing escalating. The trust had already seen a 27% reduction in the number of prescribing mistakes caused by human error following the introduction of electronic prescription charts. The IT director told us this programme was not just about digitalising paper but also a chance to rethink current practice. The projects were being designed internally which meant they could be tested by clinicians, their effectiveness reviewed and then built upon to meet the needs of the service.

The 'Without Walls' is workstream was delivering significant benefits in switching from posting paper outcome letters to GPs to delivering them electronically. The trust planned to roll out on-line patient held records across certain pathways over the next 12 months and this technology would support live chat and digital consultation, providing alternatives to face to face outpatient appointments. It would also make some services accessible to patients from within their own homes. This system would allow digital interaction between the hospital and the wider community services across Hampshire and Isle of Wight.

Some staff were concerned that the trust was going through a period of rapid digital change with little investment. It had secured £5million of funding which had to be matched by the trust and was a significant additional investment from its original IT budget of circa £1.2m a year. However, the funding would end in 2021 and this was a significant risk to future IT investment levels given the importance of IT as an enabler for transformation and driving efficiency. However, staff reported the taste for change within the trust and the need for training and knowledge development was high.

The trust learned from data security breaches. The senior information risk owner identified nine level two breaches within the past 12 months. There were no themes. The trust had appointed a data protection officer since our last inspection who escalated concerns, facilitated conversations about data protection and provided classroom training. Staff told us the trust's internal audit into cyber security, which was presented to the audit committee in February, provided assurance on areas of good practice and work was already established to improve the areas of concerns this included implementing a new password policy.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. The trust used a business intelligence and performance management software which enabled extraction of real time data. The chief executive officer gave us an example whereby data was extracted within two hours to provide assurance to another NHS trust regarding the number of trauma patients seen in December. However, it was recognised that the data was only as accurate as the information entered into the system. An improvement project within the emergency department discovered a small number of staff were recording when the ambulance arrived at the hospital rather than when the handover took place which skewed this data set.

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

The trust published its annual reports, quality accounts and board of director papers on the trust website. This included performance, safe staffing, workforce, governance and finance reporting.

Information governance systems were in place including confidentiality of patient records. During our core service inspection, we saw patients were consented for their names to be displayed on the digital whiteboards in each department.

The trust had Caldicott Guardian and a Senior Information Risk Owner who was a board member. They effectively worked as a triumvirate alongside the Chief Information Officer. They presented a report to the board every six months on the digital care strategy and the transformation programme. The trust also had a data security committee who shared reporting responsibilities. We saw outcomes of IT internal audits were presented to the audit committee in September 2019.

Engagement

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

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. The trust engaged with foundation trust members and the wider public through face to face meetings, social media and surveys. Foundation trust members received a quarterly newsletter (although only two issues were available on its website). The trust held open days as well as 'Health Focus' events throughout the year, the last one being on 22 October 2019 (Improved emergency department at Royal Hampshire County Hospital, Winchester) however this and the previous event was not filmed and shared on their website as suggested in the trust's stakeholder engagement strategy. The trust engaged with staff through a fortnightly 'Pulse' staff newsletter which shared trust successes and developments, a mid-week message bulletin which provided a roundup of 'need to know' information, posters, chief executive officer blog as well as staff Facebook and Twitter.

The trust had a structured and systematic approach to staff engagement. One of the trust's objectives was 'Empowered People' which had several priorities to help achieve the overarching trust strategy. One of the priorities included improving the visibility of leaders which was developed following the outcome of the 2018 Staff Survey. The board continued to undertake monthly 'In Touch' sessions which were broadcast live on the staff Facebook page and safety ward rounds which were in place at our last inspection. The trust had held another 'Staff Focus' week in September 2019 whereby the board visited 178 different departments with a treat trolley. The event focused on mental health awareness and wellbeing and included a bake-off competition and the opportunity for staff to take an extended break.

The trust has several trust wide initiatives to support the wellbeing of staff which included, the Zest4life programme lead by the Health4Work team and the Mental Health First Aid Training. In October 2019, the trust launched a series of weekly wellness workshops (monthly in Andover War Memorial Hospital) which provided staff advice, support and access to a range of resources including massage therapies, access to a dietetic advice and weighing, craft activities, electronic resources such as meditation and mindfulness apps. Although an average of 10 to 15 staff attended each workshop, staff reported it was a challenge to leave the wards to attend. In response, the trust was exploring the option of a road show where the workshop came to the wards.

Following the 2018 Staff Survey, the trust had developed divisional action plans which were aligned to the four trust's strategic objectives. Each action had a responsible owner, a due date and evidence of regular review. Completed actions included the introduction of six-weekly 'Meet the SMT' sessions within surgery, updating the divisional structure chart with staff photographs in medicine and to hold admin development days within family and clinical support services.

The ward/service team and division had access to feedback from patients, carers and staff and were using this to make improvements. The trust used the Friends and Family Test to ask patients whether they would recommend the services they have used based on their experiences of care and treatment. The majority of patients could complete their responses on a postcard on discharge. Emergency department patients and outpatients can complete a survey via text message or automated voice system. The trust scored between 95.4% and 96.9% between

November 2017 and October 2019. The trust's internal audit showed results between December 2018 and February 2019 showed they were on par or above the national average. There were two exceptions; maternity (postnatal care) and outpatients which both were below the national average by 1%.

Results and comments were shared with divisional leads monthly and we saw during our core service inspection, 'You said, we did' posters to show the trust's response to the feedback and changes made. We heard during the trust presentation about how in one area, to address concerns about pain management, involvement in care and discharging planning, the team set up 'lunch with matron'. The matron invited 5-6 patients to have lunch with her and have an open discussion about their experiences of the service.

The trust used patient and carer involvement in service improvement activities such as testing appointment reminder systems, reviewing patient menus and informing Trust website development in terms of accessibility and content. The trust had a virtual readers group who reviewed and made comment on patient information leaflets before these were finalised. The maternity liaison committee provided comments on the new transitional care units, 'keeping mums and babies together' leaflets. The trust captured feedback and reflections from mums to be and new mums at an open day at the maternity centre at Andover which was used in service planning.

The trust offered public Governors, training on appointment. They were actively involved in the operation of the trust. All governors were provided with an induction, a governor's handbook and supported to obtain training. New governors were buddied up with an existing governor and encouraged to attend committee and board meetings. Governors received a weekly newsletter from the chairman which contained meeting reminders which the governors felt helped bridged a gap between meetings. The head of patient and experience co-ordinated the governor visit programme which provided an opportunity for trust governors to observe the services the trust provides and to consider them against the CQC fundamental standards, and to meet patients and visitors. The governors also engaged with staff during their visits to gain their feedback about what the Trust do well and what they could improve on.

Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. The trust had developed a patient experience and engagement strategy after sourcing current strategies used by other providers and following feedback from patient led groups. This strategy was led by the chief nurse but was in its infancy.

The trust had a range of patient forums such as the patient voice forum, the Patient Experience Group (a working group of the Council of Governors), Cancer Services Partnership and the Youth Forum. We heard through the trust's presentation how the youth forum, who met quarterly, had helped to shape the care of 11 to 16-year-olds. The group had undertaken '15 steps audits' in different paediatric areas which led to the development of new menus and the adoption of the 'SHH project' which is designed to help children, young people and their carers have the best possible night's sleep in hospital.

Major changes within the trust were communicated to staff and the public. The trust implemented a trauma and orthopedic reconfiguration in December 2019. We saw the trust had engaged with staff and public groups through informal and formal consultations, focus groups, newsletters and updates via the trust website. A dedicated mailbox was set up to enable staff to email feedback to the relevant team. During our core service inspection, most staff reported they felt included in the changes and a two-way channel of communication existed.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust had a stakeholder engagement strategy which was approved in November 2019. The strategy provided a framework to help the trust engage appropriately and effectively with its stakeholders. As part of the modernising our hospitals and healthcare infrastructure programme the trust established a patient, staff and stakeholder advisory group who would have its first meeting in February 2020. The group would offer advice, views, suggestions or opinions on, for example the plan of engagement activities and the content, language, tone and style of materials such as consultation documents. Membership of this group included representatives of communities and organisations of interest from across Hampshire such as local authorities, local NHS trusts and clinical commissioning groups.

Learning, continuous improvement and innovation

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

Staff had training in improvement methodologies and used standard tools and methods. There was a shift in the trust's approach to quality improvement (QI). The trust had a quality improvement (QI) strategy dated 2018-20, that identified the principles for QI and the trust had, since our last inspection, identified a preferred methodology that all projects used. A quality improvement academy continued to train staff as QI practitioners and QI coaches. There was now a continuous improvement group who directed and led on the largest change and improvement projects linked to the trusts objectives, national change agenda, and financial priorities. The associate director for quality improvement and head of transformation sat on this group with the executive team

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. In 2019, there were around 60 projects running across the organisation and each programme had a clear governance structure, objectives, performance indicators, and reporting structure.

We heard during the trust presentation about the providing timely care improvement project in urgent and emergency care. The team recognised patients experienced increased waits in the evenings. The project looked at improving team performance and providing them with the tools to work at their best. The team made handovers more streamlined, provide new starters with a more thorough local induction and provided additional training. Following the project, the team saw team productivity had improved by 13% and there was a significant decrease in the time patients waited to be seen in the evenings.

The trust actively sought to participate in national improvement and innovation projects. The trust had recently set up an innovation board, following a piece of work commissioned from the Academic Health Science Networks, looking at opportunities for innovation across the trust. It was felt the new board had allowed the trust's innovation work to be supported centrally and sharing of learning through divisional representation.

The trust launched project 'Generation' in October 2019. The project is a Health Education England funded collaboration with non-profit organisation called 'Generation', which is aimed at recruiting disadvantaged young people (aged 18 and 19) onto the healthcare support worker apprenticeship route. A cohort of 18 young people commenced on the 7 October 2019, which was

supported by the Generation team through a four to six-week programme focusing on mind-sets, behaviours and the basic levels of technical skills required for the role.

The trust also signed up to the NHS England and NHS employers pledge to employ more people with learning disabilities. As part of this pledge, the trust had piloted easy read job applications.

The trust also took part in the Project Choice programme run by Health Education England. Project Choice aims to bridge the gap that people with learning disabilities and/or autism often experience between education and employment. The trust provided interns experience of a working environment and aimed to help them develop confidence, independence and transferable skills. The trusts first cohort graduated in July 2019 and second cohort had started. The trust employed a learning disability apprentice lead to help graduates with the transition from learning to employment.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. The emergency department team won the 'Learning Environment of the Year' award at the Royal College of Emergency Medicine's annual awards ceremony for the way that they support, train and advance the career development of emergency medicine clinicians. The department had also been nominated and shortlisted for a Health Service Journal Award 2020 for the advanced clinical practice training programme used in the trust.

The trust was actively participating in clinical research studies. Research activity doubled across the trust between April 2018 and March 2019, with 3,813 patients signing up to take part in a wide range of studies. The National Institute for Health Research (NIHR) league table for 2018/19 showed the trust was in the top 10 trusts in England for recruitment to commercial research studies. The trust was ranked as the second most improved in England for recruitment to these studies.

Within surgery, we heard how the trust was providing an innovative treatment for symptomatic benign prostatic enlargement. It had treated over 500 men and had been at the core of the successful introduction of this treatment to the UK, training over 100 surgeons from the UK and abroad. The trust had presented the initial UK results at national meeting and was involved in the National Institute for Health and Care Excellence (NICE) medical technologies evaluation programme.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. We spoke to the QI lead and the transformation lead, who told staff had really embraced QI. They had received suggestions from band 3s, consultants and senior staff. They felt QI projects definitely came from the frontline. They gave an example of QI project, where a member of staff had researched and designed a dementia café. The project took into account the needs of the people that would use it. Now there is a dementia café on both sites which is well used.

Learning from Deaths

The trust had a screening programme for inpatient adult deaths in line with its learning from deaths policy. A team of clinical screeners reviewed deaths and completed a short mortality screening form on the electronic patient record. Any deaths that triggered a concern are escalated to a team of 12 consultant structured judgement reviewers for the completion of a structured judgement review (SJR) using the Royal College of Physicians methodology. Deaths in certain patient groups such as learning disabilities, fractured neck of femur and unplanned readmissions have an

automatic review. All SJRs are reviewed by the trust's mortality surveillance group who also judge the degree of avoidability of each death.

The Trust also used a 48-hour panel process. If an incident is logged or if a case is identified via mortality review it will be presented at panel. The panel review the case and agrees the level of investigation required. All unexpected deaths would be declared as a serious incident with an investigation undertaken and presented to the Trust Serious Event Review Group (SERG). All serious incidents relating to unexpected deaths are also reviewed at the Mortality Surveillance Group. Shared learning for incidents is produced after each SERG meeting.

The trust is currently implementing a medical examiner process. A pilot was undertaken in July 2019 and a business case has been developed. At the time of inspection, the medical examiner officer and medical examiner were out to advert.

Complaints process overview

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

Question	In days	Current performance
What is your internal target for responding to complaints?	3	98%
What is your target for completing a complaint	25	58%
If you have a slightly longer target for complex complaints please indicate what that is here	n/a	
Number of complaints resolved without formal process in the last 12 months?	1,056 (October 2018 to September 2019)	

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

The trust had a system for managing complaints and escalating them as necessary. The trust treated concerns and complaints seriously, investigated them and used the learning from complaints and concerns as an opportunity for improvement. However, the trust did not provide timely responses to complaints. Only 58% of the trust's responses to complaints met the trust's timeliness targets.

The board had oversight of the complaints process and progress. The customer care team provided the trust's patient and liaison service (PALS) and followed the trust's complaint and concerns policy which was in date and provided clear guidance. However, while the policy noted that complaints might be complex or non-complex, the target response time for all complaints was 25 days; it did not set a different timeliness target for the two types of complaint.

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

The board reviewed complaints compliance monthly. The number of complaints and compliance with complaints KPIs was reported in the monthly integrated performance report to the board. The January 2020 report showed the trust had received more complaints than it did on average in 2018 for nine out of twelve months. A summary of lessons learnt and actions taken is included in the Trust complaints Annual Report and the monthly Governance Report to the Board of Directors.

The trust analysed their complaints for themes. Between October 2018 and September 2019, the top three themes for formal complaints were clinical treatment, communication and values and behaviours of staff.

As a result of learning from complaints received during the last 12 months, some changes made included:

- An improved checklist has been implemented in cardiology for post procedure discharge to ensure all patients leave with the correct advice and information leaflets
- A surgical co-ordinator is to be recruited in the dermatology service to manage the volume of patients that the speciality supports
- A new security system was put in place on Victoria ward to ensure that the ward can only be accessed by staff with a valid ID badge during specific hours
- The implementation of the ReSPECT pathway which facilitates increased family involvement in discussions regarding end of life care.

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

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

Number of complaints made to the trust

From October 2018 to September 2019, the trust received a total of 504 complaints. The highest number of complaints were for outpatients (20.4%), followed by urgent and emergency care (16.4%) and medical care (15.7%).

Core Service	Number of complaints	Percentage of total
Medical care (including older people's care)	66	13.1%
Outpatients	48	9.5%
Urgent and emergency care	48	9.5%
Surgery	45	8.9%
Maternity	15	3.0%
Services for children and young people	7	1.4%
Gynaecology	7	1.4%
Other	6	1.2%
Provider-wide	6	1.2%
Diagnostics	5	1.0%
End of life care	1	0.2%
Total	504	100%

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

Compliments

From October 2018 to September 2019, the trust received a total of 365 compliments. The highest number were for urgent and emergency care, with 25.5% of total compliments, followed by medical care (19.3%) and surgery (15.8%).

A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
Urgent and emergency services	66	25.5%
Medical care (including older people's care)	50	19.3%
Surgery	41	15.8%
Outpatients	37	14.3%
Other	23	8.9%
Not known	19	7.3%
Diagnostics	12	4.6%
Gynaecology	11	4.2%
Maternity	8	3.1%
Services for children and young people	7	2.7%
Provider wide	3	1.2%
Critical care	1	0.4%
Total	259	100.0%

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

Accreditations

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

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

Accreditation scheme name	Accreditation summary
Joint Advisory Group on Endoscopy (JAG)	Andover War Memorial – passed January 2019 Basingstoke and North Hampshire Hospital – passed January 2019 Royal Hampshire Hospital – confirmed May 2018
Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189	Biochemistry/immunology– renewed April 2019 Haematology/blood transfusion/special coagulation – renewed May 2018 Microbiology – achieved September 2018 Cellular pathology/mortuary

	services – achieved November 2018
Other	Accreditation for advanced training in gynaecology.

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

Acute services

Andover War Memorial Hospital

Charlton Road

Andover

Hampshire

SP10 3LB

Tel: 01962 863535

www.hampshirehospitals.nhs.uk

Surgery

Facts and data about this service

The trust runs a range of surgical services for inpatient and day case procedures.

Hampshire Hospitals NHS Foundation Trust provides surgical services across three sites. These are Basingstoke and North Hampshire Hospital, Royal Hampshire County Hospital and Andover War Memorial Hospital.

This inspection report is for Andover War Memorial Hospital.

Andover War Memorial Hospital

Andover War Memorial Hospital includes a 10-bedded day surgery unit with two operating theatres. It offers minor surgical procedures, dermatology (skin), one-stop menstrual disorder clinics, one-stop flexible sigmoidoscopy (examination of the large intestine) services, cataract and minor eye surgery, urology, diagnostics and endoscopy services. Surgeries that need general anaesthetic are not carried out at this hospital.

From April 2019 to September 2019 there were 1548 procedures undertaken within the day surgery unit at Andover War Memorial Hospital. Of these procedures the most commonly performed procedure was flexible sigmoidoscopy (34% of all procedures). The second most commonly performed procedure was gastroscopy (18% of all procedures). A gastroscopy is when a flexible tube called an endoscope is used to look inside the oesophagus (gullet), stomach and first part of the small intestine.

The most commonly performed surgical procedure was cataract surgery (9% of all procedures performed) followed by excision of basal cell carcinoma (5% of all procedures performed). Excision of basal cell carcinoma is the removal of skin cancer.

(Source: Hospital Episode Statistics)

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Mandatory training completion rates

Andover War Memorial Hospital

A breakdown of compliance for mandatory training courses from April to September 2019 for qualified nursing staff in surgery at Andover War Memorial Hospital is shown below:

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Conflict resolution	9	9	100.0%	90%	Yes
Counter fraud	9	9	100.0%	90%	Yes
Equality and diversity	9	9	100.0%	90%	Yes
Health and safety (slips, trips and falls)	9	9	100.0%	90%	Yes
Information governance	9	9	100.0%	95%	Yes
Moving and handling	9	9	100.0%	90%	Yes
Dementia awareness (including privacy and dignity standards)	9	9	100.0%	90%	Yes
Fire 1 year	8	9	88.9%	90%	No
Infection control	8	9	88.9%	90%	No
Basic life support	6	7	85.7%	90%	No
Immediate life support	6	7	85.7%	90%	No
Medicine management training	6	9	66.7%	90%	No

In surgery the 90% target was met for seven of the 12 mandatory training modules for which qualified nursing staff at Andover War Memorial Hospital were eligible.

Nursing staff at Andover War Memorial hospital were only required to complete basic life support training.

We reviewed more recent data supplied to us by the trust which showed overall mandatory training compliance for surgical nursing staff was 98%.

The trust did not allocate medical staff specifically to Andover War Memorial Hospital as medical staff are shared between sites.

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

Nursing staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with told us they had enough time to complete mandatory training courses. Mandatory training was a mixture of face to face and online training.

Managers checked mandatory training and alerted staff when they needed to update their training. Meeting minutes we reviewed showed leaders and staff regularly checked training rates.

The trust used an online training system for keeping a record and completion of mandatory training which was accessible to staff and managers. The application could be downloaded by staff who could then access their mandatory training record and complete mandatory training remotely. The system alerted staff and managers when training was due to expire. Staff we spoke to were positive about the system.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff knew how to identify patients at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to contact the trust safeguarding leads for advice.

Staff told us that they didn't often have to raise safeguarding concerns but were able to give us examples of different types of abuse or suspected abuse they would report. Staff told us they had recently received training on how to recognise someone who was suffering from domestic violence and what action to take.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Andover War Memorial Hospital

A breakdown of compliance for safeguarding training courses from April to September 2019 for qualified nursing staff in surgery at Andover War Memorial Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	9	9	100.0%	90%	Yes
Safeguarding children (level 1)	9	9	100.0%	90%	Yes

The 90% target was met for both safeguarding training modules for which qualified nursing staff in surgery at Andover War Memorial Hospital were eligible.

There were no medical staff allocated to Andover War Memorial Hospital as medical staff are shared between sites.

All nursing staff except one member of staff who was on long term sick leave had completed level two adult and child safeguarding training.

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

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All clinical areas we visited were visibly clean, tidy and free from dust. We saw daily cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The day unit was cleaned Monday to Friday in the evening once it had closed for the day. There was no cleaning at the weekend as the unit was closed.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. We observed staff cleaning beds and equipment between patients in theatres. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Cleaning audits for November and December 2019 showed compliance was achieved. The trust considered any overall score of over 95% as achieving compliance.

Staff followed infection control principles including the use of personal protective equipment such as aprons and gloves. We saw staff correctly dressed for theatres in line with the trust's uniform policy.

All staff were 'bare below the elbows' in clinical areas to allow effective handwashing in line with national guidelines and trust policy.

We saw staff washing their hands and using hand gel sanitiser in line with national guidelines. Hand hygiene audits provided assurances around staff compliance with hand hygiene practice. Hand hygiene data showed 100% compliance from October 2019 and January 2020. This was an improvement since our last inspection when hand hygiene data had not been submitted for three months.

The unit did not have facilities to sterilise equipment. The sterilisation of surgical instruments was undertaken at Basingstoke and North Hampshire hospital, dirty instruments were collected and clean returned once a day. There was a forty-eight hours target turnaround times for instruments. If additional instruments were needed these could be borrowed from either Basingstoke and North Hampshire hospital or Royal Hampshire County hospital. Theatre staff told us there were no issues obtaining instruments.

Staff worked effectively to prevent, identify and treat surgical site infections. The service worked to prevent hospital-acquired infections and screened patients for Meticillin-resistant Staphylococcus aureus before surgery. Patient were screened for Meticillin-resistant Staphylococcus aureus during their outpatient appointment and swabs taken for testing if thought necessary. Staff at the hospital checked patients had been screened and reviewed swab results the day before the patient came to the hospital for their procedure.

Environment and equipment

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

The day surgery unit was open from 8am to 6pm Monday to Friday. There was a staffed reception desk from 9am to 4pm. Outside of these hours patients would buzz through to clinical staff to gain access to the unit. The unit had two theatres and space for 10 trolley facilities.

Male and female patients were not segregated in separate areas, but since our last inspection procedure lists were either male or female. For example, on the day of our inspection there was a female list in the morning and male in the afternoon. The only exception to this was a one stop rectal bleeding clinic, but the only time male and female patients crossed paths was in the waiting room where everyone was fully clothed.

The service tested equipment to provide assurances around function and electrical safety. Equipment was labelled to show when it was last tested. We checked 12 different pieces of equipment across wards, departments and theatres all had passed an electrical safety test within the last 12 months. This was an improvement since our last inspection when we found equipment was overdue for electrical safety testing. We reviewed the maintenance and servicing register for all electrical equipment and found all equipment had undergone electrical safety testing and servicing within the last 12 months.

The hospital took part in Patient-led assessments of care environment (PLACE). These were annual assessments involving local people who went into hospitals to assess how the environment supported the provision of care. Assessors in the assessment completed in November 2019 said they were very confident on their first impression and final impression that a good level patient care and experience would be delivered within the environment.

Fire extinguishers were available, maintained and visible throughout the unit. This was an improvement since our last inspection when some fire extinguishers were hidden by curtains. This provided assurance that fire extinguishers were safe to use and visible to staff.

Staff checked and maintained emergency resuscitation equipment, to ensure it was available and fit for use in an emergency. We checked the emergency resuscitation trolley stored in the anaesthetic room. The trolley was dedicated to the day surgery unit and included a suction machine, defibrillator, emergency medicines and an oxygen cylinder. Records showed staff completed daily and weekly checks, providing assurances the trolleys were safe. We checked sterile items and medicines within the trolleys, and all were within the manufacturer's expiry dates. The trolley was fitted with a tamper evident tag. This was an improvement since our last inspection when the day surgery unit shared its resuscitation equipment with the birthing centre within the hospital and there was a lack of responsibility and no clear policy of whom should check the equipment.

An audit undertaken in July 2019 showed that the contents and checks of the emergency trolley were compliant with national guidelines and the trust's policy.

The service had enough suitable equipment to help them to safely care for patients.

Disposable equipment for once-only use was safe to use. We checked 14 random items and all packaging was intact and items were within manufacturer's expiry dates.

Staff disposed of clinical waste safely. Staff correctly segregated clinical and non-clinical waste into different coloured bags. This was in line with national guidance. Staff used designated recycling bins for disposal of recyclable non-clinical waste to help the environment.

The service disposed of sharps items such as needles in line with national guidelines. We checked seven sharps disposal bins which were correctly assembled, dated and were no more than three-quarters' full.

Substances subject to the Control of Substances Hazardous to Health regulations were stored securely to prevent harm.

The service had suitable facilities to meet the needs of patient's relatives. There was a waiting room, with appropriate chairs, reading material and a television where relatives could wait.

Assessing and responding to patient risk

Staff completed risk assessments for each patient to ensure only patients suitable to be treated at the hospitals were selected for treatment. Staff used a recognised tool to identify deteriorating patients.

The day surgery unit took low-risk patients and the suitability for patients attending the unit was determined by the consulting doctor in outpatients or by the referring GP. Patients who were referred for urgent investigations for example to the rectal bleeding clinic were assessed by the consultant for suitability for treatment at the unit.

The day surgery unit was only equipped to carry out procedures under local anaesthetic, regional block and sedation as there were no piped gases in the unit. This meant surgery needing general anaesthetic were not carried out in the unit.

Patients having cataract operations would go the Royal Hampshire County hospital at Winchester for their pre-assessment.

There were no consultants or anaesthetists based at the hospital, they would travel to the hospital to carry out their surgical lists. If patients needed emergency care, basic life support would be carried out by nursing staff, an ambulance called, and the patient would be transported to either Basingstoke and North Hampshire hospital or Royal Hampshire County hospital.

Staff we spoke to were clear about emergency procedures, responsibilities and what to do in an emergency, for example if a patient deteriorated or collapsed. This was an improvement since our last inspection when it was unclear what emergency response was provided at the day unit and staff were unsure of emergency procedures.

There was no emergency crash team on the Andover site, therefore staff would call 999 and carry out basic life support until the ambulance arrived. There was an automated external defibrillator on the resuscitation trolley and staff had received training on how to use it. In addition, to calling 999 staff also needed to call 2222 to alert bleep holders within the hospital to attend the emergency who could provide additional help. Staff we spoke to were clear about these processes including who would attend from within the hospital to provide support.

Staff undertook scenario training the last training was undertaken in December 2019. It was facilitated by the trust's resuscitation officer and the scenario was a patient who had collapsed in the toilet and needed basic life support. This ensured staff maintained their skills in basic life support and received feedback on how the team managed the scenario. Staff were positive about the scenario training and the support they received from the resuscitation team.

We saw laminated sheets that explained that staff needed to call 999 and 2222 to alert others to the emergency. In addition, it explained that staff needed to call 9 to get an outside line, so needed to call 9 999 to get the emergency services. This was the same to get through to the switch board at Winchester hospital, where staff needed to dial 2 to get through, so needed to call 2 2222. All staff we spoke to were aware of this.

Staff gave us an example of a recent incident when they were concerned about a patient who was experiencing pain after their procedure. The patient was transferred to Basingstoke and North Hampshire hospital within 40 minutes.

Staff we spoke to knew who and how to escalate concerns to senior staff. We saw there was information for staff on which staff to escalate to and contact numbers. The trust had a designated matron for the day who could be contacted in the first instance. We saw the matron of the day rota was displayed for staff to reference if required.

There were clearly defined roles and responsibilities in the event of a fire or on activation of the fire alarm. There were laminated signs which outlined the roles and responsibilities of staff if there was a fire. Staff we spoke to were aware of fire safety procedures. Records showed fire alarm activation panel was checked daily by staff to check it was working correctly.

A member of staff was allocated to undertake all the equipment and environment safety checks each day. Checks included checking the resuscitation trolley, anaphylaxis (severe allergic reaction), fire exits, firefighting equipment and the hypoglycaemia box. Hypoglycaemia is a condition caused by a very low level of blood sugar. Records showed these checks were completed daily.

Patients undergoing procedures under local anaesthetic and sedation had their oxygen levels and pulse monitored throughout. Patients who had received sedation had additional observations undertaken such as breathing rate. When patients received sedation, staff used National Early Warning Scores 2 (NEWS2), a recognised tool to identify deteriorating patients. We reviewed five NEWS2 charts which showed staff recorded observations and calculated early warning scores correctly. Staff told us each patient had their observations taken prior to their procedure as a base line and two sets of observations and a NEWS2 score calculated before the patient was discharged. We saw confirmation of this in the five NEWS2 charts we reviewed. This was an improvement since our last inspection when staff did not use a recognised tool to identify deteriorating patients.

The service undertook monthly audits on use of the NEWS2 tool to ensure staff were recording observations accurately and escalating patients who were deteriorating. Audit data showed in October 2019 until December 2019 100% compliance was achieved.

The World Health Organisation (WHO) Surgical Safety Checklist was used for patients undergoing minor surgery and endoscopies. An endoscopy is the examination of the inside of the body by using a lighted, flexible instrument called an endoscope. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (when the operation is completed) and debrief. We observed all five steps of the WHO checklist, and saw staff fully completed and engaged in all the required checks. This was an improvement since our last inspection when the fifth step (debrief) was not undertaken within the trust. However, on one occasion we saw the sign out was not completed until after the patient had left the theatre. This meant important information such as specific aftercare instructions may not have been communicated.

Audit data supplied to us showed 97% compliance with the fifth step of the World Health Organisation checklist from January 2019 to December 2019. Additional World Health Organisation checklist data audit we reviewed showed 100% compliance.

During the inspection we observed minor gynaecology procedures being undertaken. The checklist was not completed for these procedures. We talked to managers and the consultant gynaecologist about the reason for this. They explained that normally these procedures would be undertaken in an outpatient setting and not within a theatre where the WHO checklist would not be completed. In this case there was not the physical space at either Basingstoke and North

Hampshire hospital or Royal Hampshire County hospitals, so the theatre was utilised. We saw the consultant undertook a thorough medical history and confirmed the identity of the patient. This ensured any risks were identified and confirmed it was safe to undertake the procedure and it was the correct patient. We also observed that the consultant a theatre team had a briefing before the list started. Each patient was discussed including any past medical history, allergies and medicines and equipment requirements.

The service audited compliance with the WHO checklist. For example, data collected in theatre two from August 2019 to December showed 100% compliance with all five steps. This showed an improvement since our last inspection when step five was not undertaken.

The service had 24-hour access to mental health liaison and specialist mental health support, if staff were concerned about a patient's mental health. Staff knew how to contact the team at one of the other hospital sites for support.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The day surgery unit had core staff who had worked there for several years and had a very low turnover of staff. There was a mixture of full and part time staff. There was one eye procedure list once a week which was supported by an anaesthetist and an operating department practitioner as local anaesthetics injections were given. All activity was planned in advance therefore this made staffing easier.

The unit was staffed with a multi-flexible team of registered nurses, and healthcare assistants, who could work in all areas of the department. This helped maintain safe staffing levels. Staff described how they worked flexibly to cover different areas demonstrated a willingness to support their colleagues.

Andover War Memorial Hospital

The table below shows a summary of the nursing staffing metrics in surgery at Andover War Memorial Hospital compared to the trust's targets, where applicable:

Surgery annual staffing metrics							
October 2018 to September 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	12	4%	0%	4.9%			
Qualified nurses	7	8%	0%	7.6%	0 (0%)	0 (0%)	0 (0%)

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

Nursing Bank Agency tabs)

Nurse staffing rates within surgery at Andover War Memorial Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use and agency use.

Vacancy rates

The service had low vacancy rates.

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

Turnover rates

The service had a zero-turnover rate.

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

Sickness rates

The service had a low sickness rate.

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

Bank and agency staff usage

The service did not use any agency staff but did use bank staff.

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

Medical staffing

There were no surgical consultants and registrars based at the Andover War Memorial hospital or on the day surgery ward. Medical staff from the other two sites, Basingstoke and North Hampshire hospital and Royal Hampshire County hospital went to the Andover site to carry out minor surgery, other investigatory and endoscopy procedures.

Staff told us if they were concerned about a patient after the consultant had left the unit, they could contact them for advice on the telephone. Staff gave us examples of when this had happened.

Records

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

Staff kept detailed records of patients care and treatment. We reviewed six patient records and found they were clear, up-to-date and easily available to all staff providing care. Staff had signed and dated all entries in line with General Medical Council standards and Nursing and Midwifery Council.

The trust used two different record keeping systems with some data stored electronically and other data stored in the paper-based record. Patients records were requested and available up to 48 hours prior to surgery.

No patient records were kept at the day surgery unit. Whilst patients were present on the unit records were kept securely. Patient records were kept on the desk at the staff station in the recovery area this area was never unattended during our inspection. At the end of surgery, the patient records were sent to the Royal Hampshire Country hospital for coding and storage. We observed staff ensuring all the relevant information was completed before the notes were considered ready for collection.

The day surgery unit used an electronic patient management system that tracked the patient during their visit to the unit. During our inspection we observed staff using this system.

Patients received continuity of care after discharge. Discharge information was sent automatically electronically to the patient's GP after discharge.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, we found medicines used for general anaesthetics within the unit where general anaesthetics were not performed.

During our inspection we found medicines used in general anaesthetics and the unit did not undertake general anaesthetics. The day surgery unit did not have the equipment needed to support anaesthetics or suitably trained staff. We asked managers during and after the inspection why these medicines were kept in the unit. Managers told us at the time of the inspection that they were kept in case of complications in a patient who had a regional anaesthetic eye block, when there would be an anaesthetist and an operating department practitioner present.

After our inspection the trust told us that the decision to keep these medicines at the unit had been reviewed by the Anaesthetic Clinical Director in conjunction with colleagues. The decision has been taken to keep these medicines on this site as some lists had anaesthetists undertaking regional anaesthetic ophthalmic (eye) blocks, with operating department practitioner support, and in the theoretical event of accidental cerebrospinal fluid injection of local anaesthetic or anaphylaxis, the ability to anaesthetise the patient and intubate, whilst waiting for support to arrive was good practice. In addition, the trust said they were undertaking a review of the medicines and equipment needed in these the unit. There were no risk assessments in the use of these medicines or governance surrounding them. There was no piped oxygen, anaesthetic machine or ventilator within the unit, so it was not clear how the patient would be kept safe whilst awaiting support.

Staff stored and managed all medicines and prescribing documents in line with the trust's policy and legislation. Medicines (including controlled drugs) were stored securely. Controlled drugs are medicines liable for misuse that are controlled under the Misuse of Drugs legislation. Two qualified nurses checked the stock level of controlled drugs daily. We reviewed controlled drug storage and saw documentation of daily checks with no gaps. We checked two randomly selected controlled drugs and saw the quantity stored in the controlled drugs cupboard matched the quantity recorded in the controlled drugs book.

The unit stored refrigerated medicines at the correct temperatures to remain effective. Staff checked and recorded the fridge temperatures daily. We reviewed records and saw completed fridge temperature monitoring records, with no gaps in daily checks. There was clear guidance for staff to escalate any temperatures out-of-range.

All medicines were stored safely in dedicated cupboards. This was an improvement since our last inspection when we found they were not stored separately to other items such as coffee and stationary items. We randomly checked 16 different medicines, and all were within the manufacturer's expiry dates and in the original boxes. We reviewed records which showed expiry dates were checked monthly. This was an improvement since our last inspection when we found expired medicines and an assortment of medicines not in the original boxes had accumulated.

Staff monitored the temperature in the cupboard which contained medicines. This ensured medicines were stored in line with manufacturer's guidelines. This was an improvement since our last inspection when room temperatures were not monitored.

All intravenous (into a vein) fluids were checked monthly to ensure they were within the manufacturer's expiry date. We reviewed records which confirmed this.

There were specific medicine boxes in wards and departments to deal with emergencies such as hypoglycaemia (low blood sugar) or anaphylaxis (extreme allergic reaction). When we checked these boxes, they contained medicines on the contents list and were in date. This was an improvement since our last inspection when we found these were not regularly checked and contained expired items.

A pharmacy technician visited weekly and provided pharmacy support and there was a dedicated pharmacist for the unit. This was an improvement since our last inspection when there was no pharmacy presence on site. The pharmacy technician maintained stock levels and ordering of medicines weekly, if additional supplies were needed staff could email the technician who organised supplementary medicines. There was a stock list including stock levels of all medicines within the unit. This was an improvement since our last inspection. Staff were positive about the improved pharmacy support and medicine management within the unit.

Since our last inspection the trust had implemented mandatory medicine management training. Data supplied to us showed that 88% of nurses at Andover War Memorial hospital had completed medicine management training. This was almost in line with the trust target of 90%.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with trust policy.

All staff knew what incidents to report and how to report them. Staff explained that incidents were reported using an electronic reporting system. Staff gave us examples of incidents they had reported and confirmed they received feedback about the incident.

Staff received feedback from investigation of incidents and could describe learning and changes to practice following incidents. Examples given to us included closer working with admission teams to ensure the right booking of lists to ensure no mixed sex breaches.

The service used a variety of methods to ensure staff received feedback about incidents and were made aware of safety alerts. Information was emailed to staff and spoken about in daily huddles,

meetings and debriefs. For example, we saw meeting minutes from a debrief in January 2020 which showed new patient safety alerts were reviewed and action taken if needed.

The trust supplied us with incident data for the day surgery unit. From 1 October 2019 to 30 September 2019 there were 15 incidents reported of these 93% resulted in no harm and 7% resulted in low harm. We reviewed the incidents and did not find any themes.

The incidents we reviewed showed that managers investigated incidents thoroughly. We saw each incident had learning identified nominated person for completing any actions and time lines.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The Duty of Candour regulation was the topic for the month for December 2019. We saw staff were given information about the regulation and what it meant for them. This ensured staff understood the regulation.

Never events

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

From December 2018 to November 2019, the day surgery unit at Andover War Memorial hospital did not report any never events or serious incidents.

Safety thermometer

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

Safety thermometer data was displayed for staff and patients to see.

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

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

From December 2018 to November 2019, the day surgery unit at Andover War Memorial hospital did not report any falls with harm, no new pressure ulcers and no new urinary tract infections in patients with a catheter.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This included the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons (RCS). For example, we reviewed five patient records and saw all had physiological observations recorded at the time of their admission or initial assessment. This was in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.

In theatres, we saw the theatre team was following the World Health Organisation (WHO) Surgical Safety Checklist and 'five steps to safety' surgical approach. We observed that the fifth step (debrief) was undertaken, this was an improvement since our last inspection when it was not undertaken trust wide.

In theatres, we saw the skin was cleaned at the surgical site immediately before incision using an antiseptic preparation. This was in line with NICE guideline NG125: Surgical site infections: prevention and treatment.

Staff accessed policies and standard operating procedures electronically through the trust intranet and knew how to do this. Policies we reviewed had version numbers and were within the review date. Paper copies were also available in some areas.

Staff we spoke with told us the unit took part in a clinical audit for outcomes and complications of clinical audit for outcomes and complications of cataract surgery. We reviewed a summary of the audit dated October 2019 which included summary of key findings and action plan with a deadline.

Staff told us that they didn't treat patients subject to the Mental Health Act within the day surgery unit.

Managers and staff reviewed audit findings and developed action plans to address any areas requiring improvement for example, the cataract audit.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff told us that patients admitted for day surgery were provided with tea and biscuits following their operation. Staff ensured they had received food and fluids prior to discharge. If patients needed to arrive at the unit fasted prior to their surgery, this information was provided to the patient during the booking process. We spoke with three patients who told us that information about fasting was provided to them via a patient booklet prior to arriving to the unit for their surgery.

Take out lunch boxes containing a sandwich, fruit and a drink were available from the hospital restaurant for patients to take home if needed.

Staff told us there was staggered admissions of patients during the day. This was in line with good practice guidance (British Association of Day Surgery 2012) which recommends that there should be staggered admissions to limit fasting and waiting times.

As the unit was a day surgery unit and patients didn't stay overnight, the ward did not use fluid balance charts and food charts to record the patient's intake and output.

Staff had access to the trust dietician for advice and support if needed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Patients were assessed and monitored regularly to check if they were in pain, and action was taken to provide additional pain relief when necessary. Staff supported those patients unable to communicate using recognised assessment tools and gave additional pain relief to ease their pain as necessary.

Staff told us that pain relief was prescribed as required. Patients we spoke with told us that they did not require pain medication. We reviewed five patient records and saw that a pain tool was used.

Staff had access to the trust-wide management team who were based at the other two hospital sites but none of the staff we spoke with had experience or had the need to access this service

If patients needed pain relieving at home after day unit surgery, they would be given medication that had been pre-prepared at the Royal Hampshire County hospital department as there was no pharmacy department based on site.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The day surgery unit had achieved accreditation standards with the Joint Advisory Group on Gastrointestinal Endoscopy for endoscopy services. Joint Advisory Group accreditation provides a framework for the quality improvement and assurance of endoscopy services.

Andover War Memorial hospital did not participate in national audits. There were no audits this service should be participating in as they were undertaking minor surgery.

However, the unit participated in clinical audit for outcomes and complications of cataract surgery. One doctor carried out basal cell carcinoma excisions audits for dermatology and ear nose and throat annually and benchmarked the findings against the British Association for Dermatology. The audit findings were still being analysed at the time of the inspection.

Other local audits the service undertook included used National Early Warning Scores 2, the World Health Organisation Safer Surgery Checklist, hand hygiene and infection prevention and control. We reviewed meeting minutes which showed performance in audits was monitored to improve patient outcomes.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The trust had an induction programme for newly appointed staff and agency staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. We saw a completed induction programme in a staff file we reviewed. Staff had access to and undertook e-learning training modules through the trusts education and development system.

We saw posters in the staff room advertising 'topic of the month' and covered topics such as learning disability and the Duty of Candour regulation.

Staff we spoke with told us that their competency was reviewed every six months and appraisals took place once a year. We reviewed two staff files and saw confirmation these were completed. The staff files showed staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

The appraisal system had recently changed to an electronic system, the same system used for mandatory training. Staff were positive about the new appraisal system.

Managers supported the learning and development needs of staff through regular, constructive clinical supervision of their work. Staff explained they had extended debriefs at the end of the day when this was completed.

The day surgery unit did not use agency staff.

Appraisal rates

Andover War Memorial Hospital

As at September 2019, 93.3% of required staff in surgery Andover War Memorial Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below.

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Administrative and clerical	6	6	100.0%	90%	Yes
Add prof scientific and technical	1	1	100.0%	90%	Yes
Nursing and midwifery registered	7	8	87.5%	90%	No
Total	14	15	93.3%	90%	Yes

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

Multidisciplinary working

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

Staff told us there was a good working rapport between all staff working within the day surgery unit and within Andover War Memorial hospital. We saw this during our inspection. All staff regardless on grade or role worked together as a team.

Access to specialist advisors or other services such as therapist input, pharmacy support and the was via the Royal Hampshire County hospital.

Staff we spoke with told us information to different teams was shared through secure email. For example, if a patient needed to be referred to a specialist nurse for input this was done via email. Staff gave us examples of when this had happened.

A doctor showed us that a patient having a re-excision of a cancer on the skin had been discussed at a multidisciplinary meeting at Royal Hampshire County hospital. The purpose of the meeting was to review the findings of the cancer that had been removed and to agree treatment.

Staff worked with other agencies when required to care for patients. Staff gave us an example of when they had arranged a district nurse to support a patient at home with instilling eye drops.

Seven-day services

The day surgery unit was operational from 8am to 6pm Monday to Friday only.

There was no pharmacy department at the hospital and no dedicated physiotherapists or occupational health therapists attached to the unit.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Patients we spoke with told us they were involved in their care. They felt information was explained by staff in ways they could understand. They felt they were involved and supported in the decision-making process of their treatment.

We saw some health promoting leaflets and posters on infection control, domestic abuse and information for carers. These were displayed in the waiting room of the day surgery unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us if they were worried about a patient's mental capacity to give consent, they would seek advice from senior team members.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff told us that this did not happen often within the day surgery unit.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We reviewed eight consent forms

and found all were legible, and had documented the risks and benefits of surgery, in line with General Medical Council guidance.

We observed the consenting process for three gynaecology procedures, the consultant explained thoroughly the different treatment options available, the benefits of the surgery and complications. The consultant checked they had been sent the preoperative information about the procedure and read it. However, of the three patients we observed the consenting process for, two had not received the information prior to their procedure. The consultant apologised for this and we saw they emailed the admission team to highlight the error.

Mental Capacity Act and Deprivation of Liberty training completion

Andover War Memorial Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training modules from April to September 2019 for qualified nursing staff in surgery at Andover War Memorial Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	7	8	87.5%	90%	No

In surgery the target was met for MCA/DoLS training modules for which qualified nursing staff at Andover War Memorial Hospital were eligible.

There was only one member of staff not up- to date with Mental Capacity Act training and they were on long term sick leave.

The trust did not allocate medical staff to Andover War Memorial Hospital specifically as medical staff are shared between sites.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff using distraction techniques with patients in theatre during their procedure.

A comment on a thank-you card we saw from a patient said "Thank you for looking after me. Your kind, cheerful, patient and thoroughly professional approach made my experience yesterday far less daunting than I had imagined".

Staff explained to patients having local anaesthetic that they may feel their heart racing due to the adrenaline in the local anaesthetic. We observed one patient asking "is this normal" during a procedure and staff providing reassurance that it would go off in a minute.

Patients said staff treated them well and with kindness. We observed staff provided reassurance during procedures and explained everything that was going on and the different noises they may hear.

Staff followed policy to keep patient care and treatment confidential. We observed when patients were in the consulting room with staff the sign on the door was changed to do not enter consultation in progress.

We observed when staff took patients into theatre for their procedure, they introduced them by their name and what they liked to be called.

Staff respected patients' privacy and dignity. When patients were getting changed staff pulled the curtains round and waited outside so nobody could enter whilst they were changing.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Throughout our inspection, we observed staff supporting patients, responding to their needs and communicating in an appropriate way. We observed a member of staff asking a patient if they would like a hand to hold during their procedure.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff signposted patients and relatives to organisations and groups who could provide support.

We saw compliment and thank-you cards received from patients displayed in the waiting room. Comments from patients in a 2019 patient survey included "excellent care" and "all the staff here are very fantastic, made my stay very relaxing".

There was a chaplaincy service that provided spiritual, religious or pastoral support to patients at any time of the day or night. Patient information boards in the hospital had details of how to contact the service.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. During the discharge of a patient we heard a member of staff ask the patient if they would like them to explain everything to their wife.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff gave us examples of different aids available for patients with difficulties communicating.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their families were invited to complete feedback questionnaires.

Staff supported patients to make informed decisions about their care. We observed staff checked patients had understood all the information given to them during their consultation. One patient commented “you have explained everything very well” when asked if they had any questions.

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. For example, patients had commented about waiting times, so there was now a notice in the waiting room explaining the appointment time on their letter may not be the time they are treated.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The day surgery unit at Andover War Memorial hospital undertook minor surgery and procedures for patients living in Andover and the surrounding areas. Patients were referred by the consulting doctor in outpatients or by GP referral.

The day surgery unit carried out short procedures normally needing one hour in the department, with one stop clinics for rectal bleeding and gynaecology procedures, cataract surgery, minor surgery such as cyst removal and excision of skin cancers.

The unit had a waiting room which provided comfortable seating, enough toilets, a water dispenser and tea and coffee upon request. There was also a restaurant located on site which served a variety of refreshments.

Staff told us patients preferred treatment at Andover War Memorial Hospital. This was due to day surgery environment being smaller and less busy and the ease of parking at the hospital.

Patients we spoke with said they never had issue with finding parking at the hospital. Signage was adequate to direct patients to the right area.

Staff monitored the wait times and informed the patients if the unit was running late.

The service relieved pressure on other departments when they could treat patients in a day. The day surgery unit was utilised for procedures which didn't necessarily need to be performed in a theatre such as gynaecology procedures, as there was not the physical space in the other two main hospital locations or waiting lists were longer.

Managers ensured that patients who did not attend appointments were contacted. An email was sent to the admission team if a patient did not turn up for their appointment.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

During our inspection we were told by the staff that if a patient needed an interpreter then this could be arranged. Staff told us that this request would normally be picked up during the booking process or be arranged by the referring GP. The unit had access to a telephone interpreting service. However, none of the staff we spoke with had experience or had the need to access this service.

We saw no information in languages other than English during our inspection, however staff told us that they could access these on the trust website and print information off if needed.

Staff gave us an example of meeting the individual needs of a patient with learning difficulties. They attended the unit before their procedure to familiarize themselves with the environment and staff. The patient didn't like a particular colour, so staff removed anything that was this colour on the day of their procedure. The patient's family were allowed to stay with them on the ward whilst they waited for surgery and whilst they recovered following surgery.

Staff told us they allowed relatives or carers to stay with patients if they needed additional support.

Staff made sure patients living with mental health diagnosis, learning disabilities and dementia, received the necessary care to meet all their needs. The unit had a learning disability link nurse and had access to a learning disability hospital liaison nurse based in Basingstoke and North Hampshire hospital for advice and support.

There was level access to the day surgery unit, which was accessible for patients with limited mobility or wheelchair bound. Patients we spoke with were happy with the parking facilities.

Patients who needed their wound to be checked after surgery were given a choice of which hospital they would like to attend, whichever was the most convenient for them.

The hospital used a centralised administration service for the surgical teams, and this was based at the Royal County Hampshire hospital site. Staff we spoke with told us the booking team completed a booking form which recorded patient needs and any mental health conditions or learning disabilities. Staff told us the booking team and the consultants selected patients that could be treated in the day surgery unit. Patients who were considered higher risk were referred to the other two hospital sites.

Staff told us they always checked that patients had support at home once they had been discharged. If a patient did not have support at home this was identified, and staff would telephone them the next day to check on their welfare.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients were given staggered appointments, so they spent the least amount of time in the unit.

Referral to treatment time and cancelled operations were reported to us as trust-wide data rather than splitting into data for each hospital.

Referral to treatment times were above the England average for general surgery and below the England average for ear nose and throat and ophthalmology. Managers and speciality leads had developed comprehensive actions plans to address referral to treatment times. We reviewed the

action plans for ear nose and throat surgery. We saw the risks had been risk assessed and rated and there were trajectories to ensure the referral to treatment times were met. Patients that had been waiting the longest for treatment or had a suspected cancer were identified and prioritised.

Theatres monitored performance on dashboards. From January 2019 and December 2019 theatre utilisation for all theatres across the trust was 86%.

Cancelled operations

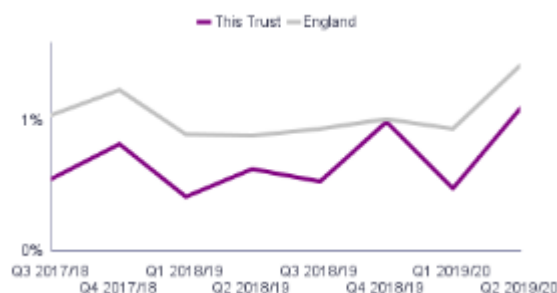
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Over the two years, the percentage of cancelled operations at the trust showed that trust performance was better than the England average in three quarters, the same in same in two and worse in one quarter. In Q1 2017/18 and Q3 2017/18 the highest percentages of cancelled operations were reported with 11% and 10% of operations cancelled respectively.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Hampshire Hospitals NHS Foundation Trust



Cancelled operations as a percentage of elective admissions - Hampshire Hospitals NHS Foundation Trust



Over the two years, the percentage of cancelled operations at the trust were mostly better (lower) than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients and relatives, we spoke with told us that they would speak to a member of staff if they wanted to complain or raise concerns. We saw that there were posters in the waiting room which explained and gave details of the way patients could make complaints. Patients could also find information on how to make a complaint on the trust's website under the patients and visitors section.

Staff in the unit told us that any complaints or concerns would normally be addressed at once by a member of the team before concerns escalated and became formal complaints. Staff told us they referred patients to the Patient Advice and Liaison Service who offered help, advice, support and potential resolution to those wishing to make a complaint.

Staff told us feedback from complaints and concerns were discussed during daily briefings and ward meetings. We saw a you said we did poster in the waiting room where patients had complained about the waiting times and the unit had responded by providing this information on the board.

Summary of complaints

Trust level

From October 2018 to September 2019 the trust received 164 complaints in relation to surgery at the trust (16% of total complaints received by the trust). The trust took an average of 27.8 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be investigated and closed within 25 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	56	34.1%
Communication	31	18.9%
Admissions and discharges	19	11.6%
Patient care	19	11.6%
Values and behaviour	18	11.0%
Appointments	8	4.9%
Trust admin/policies/procedures	3	1.8%
Waiting times	3	1.8%
Access to treatment and drugs	2	1.2%
Other	2	1.2%
PDW	2	1.2%
Prescribing	1	0.6%
Total	164	100.0%

Andover War Memorial Hospital

From October 2018 to September 2019 the trust received two complaints in relation to surgery at Andover War Memorial Hospital. The trust took an average of 19.0 days to investigate and close

complaints. This was in line with their complaints policy, which states complaints should be investigated and closed within 25 working days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Appointments	1	50.0%
Clinical treatment	1	50.0%
Total	2	100.0%

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

Number of compliments made to the trust

From October 2018 to September 2019 there were 41 compliments received for surgery at the trust (15.8% of all received trust wide). There were no compliments received for Andover War Memorial Hospital.

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

Is the service well-led?

Leadership

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

The trust was divided into three divisions, medical division, surgical division and the family and clinical support division. Each division had a director and an operational director they were supported by a nursing director and a deputy director.

The surgical division was formed of seven specialties these were, surgery, head and neck, peritoneal malignancy, trauma and orthopaedics, cancer services and critical care and anaesthetics. Each speciality had a clinical director, an operational service manager and the cancer and peritoneal malignancy divisions had a deputy operational manager. The surgery and head and neck specialties had an operational service lead.

There was one trust-wide surgical division management team that worked across the three sites. Senior management staff working in the surgical services mainly divided their time between the Basingstoke and Winchester hospital sites with an office at each location.

There were three clinical matrons working at Andover war Memorial hospital site, however, the day surgery unit did not come under their remit, but they provided the day surgery unit with day-to-day advice and support. The clinical matron responsible for the day surgery unit was mainly based at Royal Hampshire County hospital. The day care unit was run day to day by a senior sister who provided clinical support to the team. Staff told us that support and visibility from the surgical leadership team had improved since our last inspection. A member of staff told us “there is always support if you need it”.

There was a new operational service manager and staff reported that they had visited the unit and was very supportive and approachable. Staff knew who to escalate concerns or issues to and the escalation process, contact details and the matron of the day rota was displayed for staff to access.

Vision and strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, staff at Andover War Memorial hospital were not aware of a vision or strategy for the service they provided.

The trust had four high level strategic objectives for 2018-2022. These were outstanding care for our patients, empowered staff, living within our money and innovating for the future. The strategic objectives had been developed with engagement with staff, governors, stakeholders and the board. Staff we spoke to were aware of the high-level strategic objectives for 2018-2022. Senior leaders were able to describe some areas of progress against the strategic objectives, such as the orthopaedic and urology transformation projects.

The strategy for the surgical division, was clearly linked to the trust's strategic aims, including financial sustainability, improve theatre productivity, move more elective procedures to day case, and more day case to outpatients, building new facilities and developed orthopaedic services. Managers had achievable plans of how to turn the strategy into action. Senior leaders were able to describe some areas of progress against the strategic objectives.

Staff could describe how they applied the trust values in their day-to-day work. We saw posters and computer screen savers displaying the trust values on noticeboards on the wards. The trust values were CARE; Compassion - caring about our patients and our colleagues; Accountable and responsible, always improving; Respect for all – colleagues, patients and their families and Encouraging and challenging each other to always do our best.

Staff we spoke to were proud of the service they provided to patients. They were unaware of whether there would be any changes to the services in the future. There was no vision or strategy for the development of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff said they enjoyed working at the hospital. Staff spoke positively and passionately about the service meeting the needs of the local patients and the surrounding areas. Staff comments to us included "I absolutely love it here" and "we are a family and know each other inside and out".

We saw posters and computer screen savers with details of the trust's freedom to speak up guardian, should staff wish to raise any concerns in confidence.

Staff we spoke to felt respected, valued and that morale was good. All staff felt comfortable to raise concerns and were confident they would be listened to by managers.

We saw in departmental meeting minutes that staff wanted to develop an ethos for the unit and all staff were going to be involved in developing it.

Governance

Leaders used effective governance processes, however these were local to the day surgery only. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The surgical division held a variety of monthly governance meetings, these included theatre governance meetings, speciality governance meetings such as orthopaedics and general surgery and surgical division quality governance meetings. These fed into the surgical board meeting chaired by the medical director, which in turn fed into executive governance committee.

The day surgery unit had regular formal meetings with agendas and meeting minutes produced for staff to review if they were unable to attend the meeting. However, these meetings were focussed on the day surgery unit and the service they provided and did not include any information from wider within the surgical division.

This did not provide assurance that key information and learning from within the whole surgical division was shared with staff, or that information from the unit meetings were fed back to the surgical division.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events for example, bad weather.

Increased visibility and oversight by senior staff within the surgical division meant there was better awareness of risks to the service, however this still needed embedding and improving. For example, senior managers were not aware that general anaesthetic medicines were kept within the unit. This did not provide assurance that the risks of this had been assessed and mitigated,

Locally staff managed and discussed risk and issues. However, it was unclear what the formal process was to manage risk, issues and performance between staff in the unit and senior managers.

Staff used the World Health Organisation Safer Surgery Checklist for some procedures but not all. This meant there might be confusion over which procedure it was meant to be used for. However, staff were able to tell us which procedures it was used for. We saw on one occasion that the sign out stage of the checklist was completed after the patient had left theatre. This meant that there was a risk that important checks had not verified and information about after care not communicated.

The service managed risks well. In addition, to the surgical division risk of the risk register there were two risks specifically for the day surgery unit. We saw both risks had been reviewed within the last 12 months, were risk assessed as low risk, had measures to mitigate the risk and a responsible manager allocated to both risks.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information systems were secure. We saw staff followed information governance principals, such as locking their computer screens when unattended. Staff told us they were able to access the information they needed to carry out their roles. Staff showed us that they were able to access trust wide computer systems to obtain investigation results.

The trust was implementing a Digital Care programme over the next three years. This aimed to improve the way the trust communicated with patients to reduce the amount of paper used and allowed patients access to more information, helping them to take control of their own care.

The service shared relevant performance information with staff and patients. Staff undertook monthly audits and inputted data into a data collection system which monitored a variety of different safety measures. These included the number of patient falls, hand hygiene compliance and National Early Warning Score 2 compliance. This information was reviewed and shared with staff at meetings. However, information from the day surgery unit was mainly amalgamated with information from the Royal Hampshire County hospital.

Engagement

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

The hospital took part in patient-led assessment of care environment assessments. They were annual appraisals involving local people called patient assessors who go into hospitals to assess how the environment supports the provision of care. Areas looked at include cleanliness, food and hydration, privacy, dignity and wellbeing, condition appearance and maintenance, dementia, and disability. On the whole the hospital performed well in the 2019 patient-led assessment of care environment assessment.

The trust held patient forums and community engagement events. The trust hosted an event to discuss with local people, staff and key stakeholders how they were responding to the commitments set in the national NHS Long Term Plan.

Health Focus events were held regularly in the local geographical area. They were open to everyone and included a presentation by a senior clinician on a range of health-related topics.

A Health Focus event was held in Andover in March 2019 this provided an update of the work being carried out on the hospice expansion. A matron from the hospice talked to local people about the plans and they had the opportunity to view the plans, as well as hear about the difference that the redevelopment will make for both patients and staff and the fundraising efforts taking place to make it happen.

A Health Focus event was planned for March 2020 and the focus will be about the services provided at Andover War Memorial Hospital with patients and the public having the opportunity to speak to staff who work there.

Patients, the public, partners and staff all had the opportunity to take part in a survey about the trust objectives and priorities for 2019/20 in January 2019 across each of the three hospital sites.

Out of the 1,044 people who responded 617 were staff and 562 were patients, carer's, a member of the trust, a member of the public or a volunteer.

To support the development of the Digital Care programme the trust asked patients and carers to take part in a survey to give their views on the use of technology in the delivery of healthcare. Members of the patient voice forum and Patient Experience Group supported the survey programme, providing a patient perspective and informing the development of systems and information for patients and the public.

The surgery division had developed an action plan to address the worst performing areas in the 2018 staff survey. There were 12 action, all actions had a nominated individual and a time scale. Of the 12 actions eight had been completed. Actions included introducing 'You're amazing mugs' as local WOW awards, rotational roles for staff, a structured pathway for the first year for new staff and weekly ward rounds by members of the management team.

The trust took part in the national WOW! awards which recognised outstanding customer service. Hampshire hospitals staff can be nominated for an award by their colleagues, patients or visitors, with a handful of winners selected by the trust's public governors each month.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Quality improvement methods were used and participation in research was limited.

Due to the nature of the procedures undertaken participation in research was limited. However, staff did tell us they received training on a new technique and equipment used in endoscopy procedures.

The service had made improvements since our last inspection. Medicine management, pharmacy input, emergency equipment and emergency procedures had improved.

Staff undertook scenario training supported by the trust resuscitation team. This ensured their skills were kept up-to-date and staff received feedback on areas that went well and areas for improvement.

The service had identified different procedures and services which could be undertaken within the unit and were in the process of planning the implementation.

The service was succession planning to ensure it had the staff with the necessary skills and knowledge, for the future. Junior staff were supported to develop their leadership skills, and also had the opportunity of cross-site working to gain exposure to different specialities to advance their skills.

Royal Hampshire County Hospital

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Urgent and emergency care

Facts and data about this service

The emergency department at Royal Hampshire County Hospital (RHCH) forms part of the unscheduled care division. Front door services include three resuscitation bays, a dedicated emergency department paediatric area (EDPA), an emergency decision unit, 10 high care in-patient beds, six assessment trolleys and six chairs for medical assessment, along with 28 in-patient medical assessment beds.

Ambulatory emergency care and GP referrals can be seen in the newly appointed same day emergency care facility (SDEC) and the three newly created rapid assessment and treatment bays (RAT).

Basingstoke and North Hampshire Hospital provides an emergency service through a Type 1 emergency department. Services include trauma and cardiology, an emergency decision unit, a dedicated paediatric department and same day medical assessment for ambulatory medical patients. Furthermore, there is a minor injuries service provided by emergency nurse practitioners.

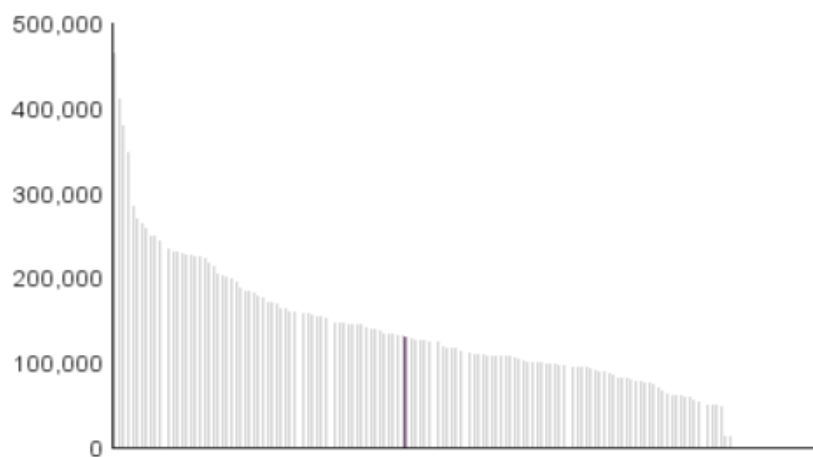
Details of emergency departments and other urgent and emergency care services

- Basingstoke and North Hampshire Hospital – Emergency department and minor injuries unit
- Royal Hampshire County Hospital – Emergency department
- Andover War Memorial Hospital – Minor injuries unit

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

Activity and patient throughput

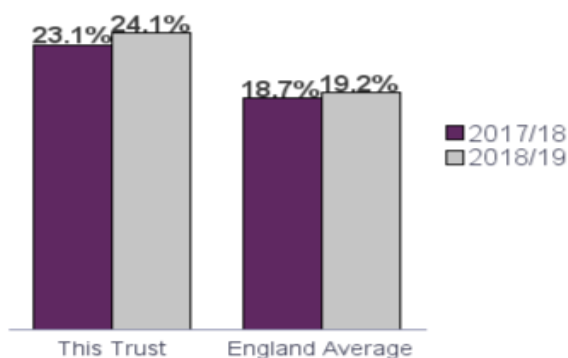
Total number of urgent and emergency care attendances at Hampshire Hospitals NHS Foundation Trust compared to all acute trusts in England, July 2018 to June 2019



From July 2018 to June 2019 there were 129,773 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

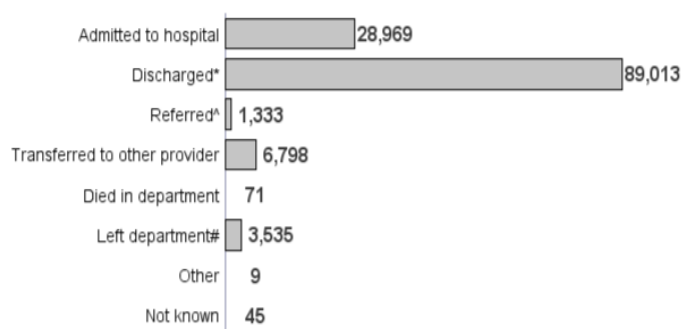
Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2018/19 compared to 2017/18. In both years the proportions were lower than the England averages.

(Source: NHS England)

Urgent and emergency care attendances, from July 2018 to June 2019



* Discharged includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training.

The trust set a target of 90% for completion of mandatory training, except for the module information governance which has a target of 95%.

Trust level

A breakdown of compliance for mandatory training courses from April to September 2019 at trust level for registered nursing staff in urgent and emergency care is shown below:

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Counter fraud	164	172	95.3%	90%	Yes
Equality and diversity	164	172	95.3%	90%	Yes
Dementia awareness (including privacy and dignity standards)	164	172	95.3%	90%	Yes
Health and safety (slips, trips and falls)	162	172	94.2%	90%	Yes
Conflict resolution	151	172	87.8%	90%	No
Fire 1 year	149	172	86.6%	90%	No
Information governance	148	172	86.0%	95%	No
Basic life support	140	172	81.4%	90%	No
Immediate life support	140	172	81.4%	90%	No
Moving and handling	137	172	79.7%	90%	No
Infection control	126	172	73.3%	90%	No
Medicine management training	84	172	48.8%	90%	No

In urgent and emergency care the 90% target was met for four of the 12 mandatory training modules for which registered nursing staff were eligible. Nursing staff did not meet the 95% target set for the module information governance.

Medical staff received and kept up-to-date with their mandatory training.

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

Training module name	April to September 2019

	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality and diversity	69	75	92.0%	90%	Yes
Conflict resolution	67	75	89.3%	90%	No
Moving and handling	66	75	88.0%	90%	No
Health and safety (slips, trips and falls)	65	75	86.7%	90%	No
Counter fraud	63	75	84.0%	90%	No
Dementia awareness (including privacy and dignity standards)	62	75	82.7%	90%	No
Basic life support	61	74	82.4%	90%	No
Immediate life support	61	74	82.4%	90%	No
Information governance	54	75	72.0%	95%	No
Fire 1 year	48	75	64.0%	90%	No
Infection control	45	75	60.0%	90%	No
Medicine management training	17	75	22.7%	90%	No

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

In urgent and emergency care the 90% target was met for one of the 12 mandatory training modules for which medical staff were eligible. Medical staff did not meet the 95% target set for the module information governance.

Royal Hampshire County Hospital

Nursing staff received and kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2019 for registered nursing staff in urgent and emergency care at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Counter fraud	59	62	95.2%	90%	Yes
Equality and diversity	59	62	95.2%	90%	Yes
Dementia awareness (including privacy and dignity standards)	59	62	95.2%	90%	Yes
Health and safety (slips, trips and falls)	57	62	91.9%	90%	Yes

Information governance	53	62	85.5%	95%	No
Fire 1 year	52	62	83.9%	90%	No
Conflict resolution	49	62	79.0%	90%	No
Infection control	47	62	75.8%	90%	No
Basic life support	46	62	74.2%	90%	No
Immediate life support	46	62	74.2%	90%	No
Moving and handling	46	62	74.2%	90%	No
Medicine management training	28	62	45.2%	90%	No

In urgent and emergency care the 90% target was met for four of the 12 mandatory training modules for which qualified nursing staff at Royal Hampshire County Hospital were eligible. Nursing staff did not meet the 95% target set for the module information governance.

A breakdown of compliance for mandatory training courses from April to September 2019 for medical staff in urgent and emergency care at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Conflict resolution	20	22	90.9%	90%	Yes
Moving and handling	20	22	90.9%	90%	Yes
Counter fraud	19	22	86.4%	90%	No
Equality and diversity	19	22	86.4%	90%	No
Basic life support	18	22	81.8%	90%	No
Immediate life support	18	22	81.8%	90%	No
Health and safety (slips, trips and falls)	18	22	81.8%	90%	No
Dementia awareness (including privacy and dignity standards)	18	22	81.8%	90%	No
Medicine management training	12	22	54.5%	90%	No
Information governance	12	22	54.5%	95%	No
Fire 1 year	10	22	45.5%	90%	No
Infection control	9	22	40.9%	90%	No

In urgent and emergency care the 90% target was met for two of the 12 mandatory training modules for which medical staff at Royal Hampshire County Hospital were eligible. Medical staff did not meet the 95% target set for the module information governance.

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

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Medical staff received and kept up-to-date with their mandatory training. The updated compliance figures we received during the inspection for the medical staff mandatory training had significantly improved (December 2019). For example, consultant staff achieved 100% compliance in five of the modules above and 89% in three modules. Medical staff in other grades achieved 89.7% compliance across the range of modules.

We asked the trust to supply us with updated data on compliance with medicine management training. The trust explained that there were 31 different modules for doctors and nurses in relation to medicines training in addition to the generic training. Staff completed the module most relevant to their role. This was not captured in the data above.

Managers explained that junior medical staff training was not always registered at the hospital location as much of it is completed before they began their placements.

Nursing staff compliance was discussed, managers explained that there had been a great deal of recruitment during the year and all modules are completed by nurses as part of their induction and the figures did not reflect this.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff and managers received e mails when mandatory training was due to expire and when training had expired.

The 'green brain' app was introduced in 2019 which was accessible by all staff with a smart phone. The app alerted staff to the status of their mandatory training and enabled them to complete necessary training on-line.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Trust level

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from April to September 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	161	172	93.6%	90%	Yes

Safeguarding children (level 1)	131	172	76.2%	90%	No

In urgent and emergency care the 90% target was met for one of the two safeguarding training modules for which registered nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

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

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	60	75	80.0%	90%	No
Safeguarding children (level 1)	37	75	49.3%	90%	No

In urgent and emergency care the 90% target was not met for either of the safeguarding training modules for which medical staff were eligible.

Royal Hampshire County Hospital

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from April to September 2019 for registered nursing staff in urgent and emergency care at Royal Hampshire County Hospital (RHCH) is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	56	62	90.3%	90%	Yes
Safeguarding children (level 1)	36	62	58.1%	90%	No

The 90% target was met for one of the two safeguarding training modules for which qualified nursing staff in urgent and emergency care at Royal Hampshire County Hospital were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from April to September 2019 for medical staff in urgent and emergency care at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	15	22	68.2%	90%	No

Safeguarding children (level 1)	10	22	45.5%	90%	No

The 90% target was not met for either of the safeguarding training modules for which medical staff in urgent and emergency care at Royal Hampshire County Hospital were eligible.

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

We saw updated figures during the inspection for medical staff, which demonstrated safeguarding training compliance had significantly improved. The month end compliance rate for December 2019 showed the consultant medical staff compliance rate had improved to 100% for safeguarding adults and 89% for safeguarding children. Other medical staff grades achieved 87% for safeguarding adults and 82% for safeguarding children.

The clinical matron explained that the registered nursing staff worked at level 2 for safeguarding; we did not receive the compliance figure at this level.

Nursing staff who worked within the emergency department paediatric area (EDPA) were trained to level 2 safeguarding children and were able to request support from the hospital paediatric team on Northbrook ward 24 hours a day. The clinical matron explained that the service was working towards nurses caring for children were trained to level 3 in children's safeguarding. This was not reflected in the data received from the trust.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns.

Medical staff received training specific for their role on how to recognise and report abuse.

The department used a screening tool to assess risk of physical abuse in children presenting with an injury. Staff knew about arrangements to safeguard women and children with, or at risk of female genital mutilation (FGM).

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained.

All staff completed infection prevention and control (IPC) training; compliance for medical staff in December 2019 had improved to 72.6% from 40.9% earlier in the year for medical staff. Nursing staff completed IPC training during induction and annually after that, which was not reflected in the figures.

The service generally performed well for cleanliness. The PLACE (Patient Led Audit of the Care Environment) scores in November 2019 for the emergency department in RHCH showed that all elements of the cleanliness assessment had passed. The assessments were undertaken by members of the public, former and current patients and members of Healthwatch.

Audit data provided by the trust showed that commode cleaning was well below standard.

Oct-19	Nov-19	Dec-19	Jan-20

Commode Toilet Seat %	100.0%	100.0%	50.0%	0.0%

The matron explained that the commodes were discovered to have some rusted parts which meant cleaning was ineffective, and arranged for the commodes to be replaced at the earliest opportunity.

Cleaning schedules were visible and daily cleaning records showed these were adhered to. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly including the toys in the paediatric waiting room.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We found equipment was visibly clean and labels were used to identify 'cleaned and ready for use'

Disposable curtains were in use and had dates showing when they were changed, which was every six months in line with the hospital policy.

We saw posters displayed about infection prevention and handwashing. Hand washing facilities and antibacterial gel dispensers were available throughout the department.

Patients we spoke with confirmed staff were washing their hands before and after treating them. Hand hygiene audits were completed monthly and if compliance fell below 90%, an action plan was required to address the concerns. We saw that the department had achieved 100% compliance for the months of October and December 2019 and January 2020. November's audit showed compliance level of 90%.

Staff who were not compliant with the bare below the elbow (BBE) were considered as being unable to perform adequate hand decontamination and this would be escalated to the divisional chief nurses. We did not see evidence that this had been necessary in the emergency department in RHCH.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Environment and equipment

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

The emergency department was well laid out and mostly allowed for easy access and circulation, safe working, and good lines of sight. There were security systems to prevent unauthorised access to all areas. There was a designated ambulance entrance, which was a short distance from ambulance parking bays. This allowed easy access to the resuscitation room and major treatment areas. One of the resuscitation bays was equipped for the stabilisation and treatment of children.

Improvements to the department in early 2019 included the room for patients with mental health needs which met the required standards.

The waiting area for self-presenting patients allowed the receptionists to view most of the area. The triage assessment room also opened on to the waiting room, allowing triage nurses to maintain oversight of the patients waiting there.

There was a separate secure area suitable for children and young people. It was decorated in a child friendly way. This area was separate from the main emergency department and was not overlooked by adult patients and visitors. The waiting area was observed by the nurse's station. Staff acknowledged they did not yet have an ideal waiting area for teenagers.

Records were kept showing equipment checks and maintenance requirements. Maintenance audits showed most equipment was maintained according to trust policy and maintenance schedules. We checked several pieces of equipment, including blood pressure machines, blood gas machines and infusion pumps and found evidence of up to date electrical safety testing. We checked disposable equipment within all areas of the department and saw it was in date. Staff told us they had enough equipment in the department to help them to safely care for patients, and they had adequate stocks of disposable equipment.

Staff carried out daily safety checks of specialist equipment and maintained records of this. We saw all resuscitation equipment was available and fit for purpose.

The service had suitable facilities to meet the needs of patients and their families. There were changing facilities for babies and the department was easily accessible for pushchairs and those with mobility challenges.

Staff disposed of clinical waste safely; we saw staff disposing of items safely using special containers (known as sharps bins), clinical waste bins and clinical waste bags throughout the department.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Emergency Department Survey 2018 – Type 1 A&E departments

The trust scored about the same as other trusts for all five emergency department survey questions relevant to safety.

Question	Trust score	RAG
Q5. Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.6	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.4	About the same as other trusts
Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.3	About the same as other trusts
Q33. In your opinion, how clean was the A&E department?	8.4	About the same as other trusts
Q34. While you were in A&E, did you feel	9.7	About the same as other

threatened by other patients or visitors?		trusts

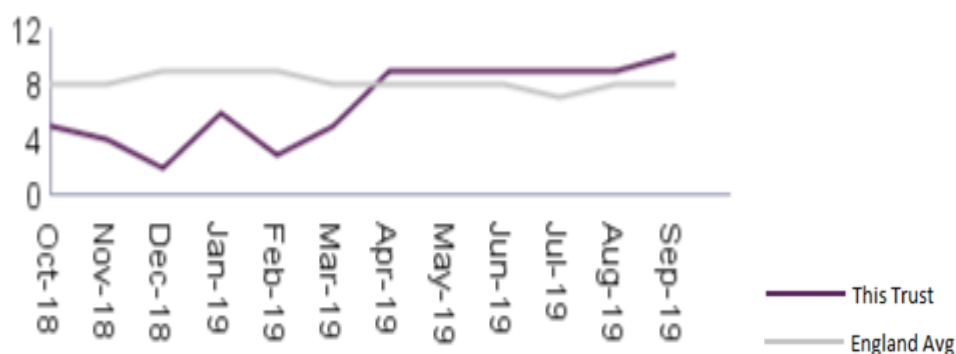
(Source: Emergency Department Survey 2019)

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

The median time from arrival to initial assessment was better than the overall England median from October 2018 to March 2019.

The figures in the graph below primarily relate to Royal Hampshire County Hospital which does not have streaming at the front door

Ambulance – Time to initial assessment from October 2018 to September 2019 at Hampshire Hospitals NHS Foundation Trust



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

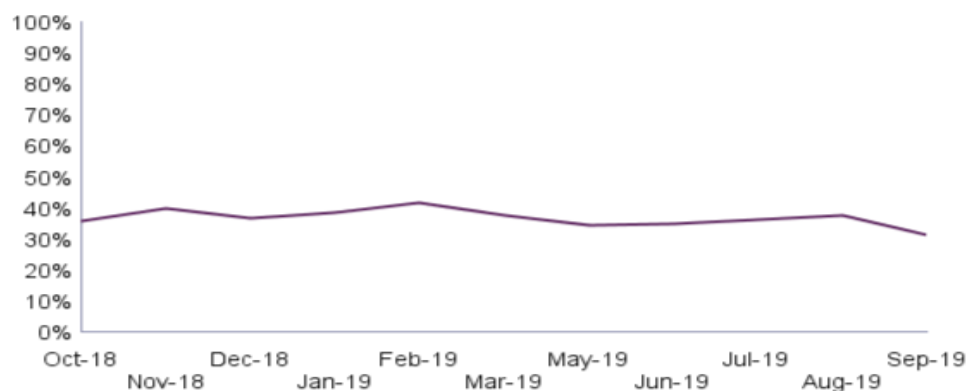
Royal Hampshire County Hospital

From October 2018 to September 2019 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Hampshire County Hospital.

Ambulance: Number of journeys with turnaround times over 30 minutes - Royal Hampshire County Hospital



Ambulance: Percentage of journeys with turnaround times over 30 minutes - Royal Hampshire County Hospital

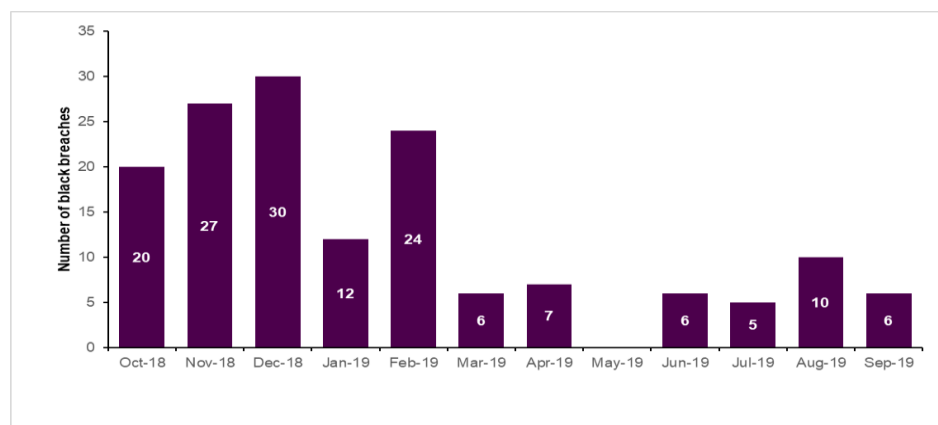


(Source: National Ambulance Information Group)

It is recognised by NHS England that delays in handover from ambulance staff to emergency department can result in increased risks to patients. Staff from the ambulance service reported that the new system following refurbishment was working well and reported a reduction in time to handover patients with reduced time spent in the department.

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From October 2018 to September 2019 the trust reported 153 “black breaches”.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Clinical staff completed risk assessments for each patient on arrival using recognised tools, such as the safety checklist which was used for all patients in the major treatment area. They reviewed these regularly, including after any incident.

Staff used a nationally recognised tool to identify deteriorating patients and escalate them appropriately. This was a time and sequence-based checklist of tasks, which was completed for all patients, from first assessment through to discharge or transfer. Tasks included hourly observations of patients’ vital signs and the calculation of a national early warning score (NEWS 2) on arrival and hourly thereafter. A monthly audit of patient records showed the service performed well on measuring vital signs and recording a NEWS score on admission and completing the checklist.

We saw staff greet patients and receive a handover from ambulance staff. They were able to prioritise patients, who then received further assessment, including investigations, by the nurse-led rapid assessment and treatment (RAT) team. There were laminated cards displaying ‘at a glance’ triggers and protocol for patients who presented with potentially life- threatening conditions, who would be categorised as high priority. These conditions included stroke, chest pain, sepsis and head injury.

There was a clear triage process with all patients receiving an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival. Triage nurses were on duty at all times to perform initial assessment and prioritise patients accordingly. They were experienced nurses who had received in-house training to perform this task. They were able to request X-rays and electrocardiograms (ECGs) to help reduce waiting times for these tests.

The staff had 24-hour access to the adult mental health liaison team and specialist mental health support if they were concerned about a patient's mental health. The service was available 24 hours a day, seven days a week for adults. Staff on the emergency department told us they mostly had a quick response from the adult service who would aim to see a patient referred within four hours. At the time of the inspection the liaison team were working towards reducing this to one hour. There was a children and adolescent mental health service (CAMHS) consultant on call 24 hours a day, seven days a week. We saw flow charts to guide staff when dealing with adult and children with mental health needs.

Staff working on the emergency department had annual training in conflict resolution. Security staff received de-escalation and restraint training every year. Staff called the police if security staff were occupied with another patient or they needed more support.

Staff shared key information to keep patients safe when handing over their care to others. We observed staff using a standard process when patient details were being handed over.

Shift changes and handovers included all necessary key information to keep patients safe. We observed patient handovers with all relevant information being shared.

There was a paediatric consultant based in the department four days per week and there were established links with the ward based paediatric team close by. We saw examples of cross disciplinary working between the two departments.

Staff told us about recognition of cancer patients and any other patients at risk of infection and how they ensure the patient's safety; examples given included isolation from the department for patients with increased infection risks.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, using bank and regular agency staff when required.

Royal Hampshire County Hospital

The service had enough nursing and support staff to keep patients safe. There were vacancies but managers always made every effort to enlist bank or agency staff to fill any gaps in the roster.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants. The nurse-in-charge assessed and reviewed staffing levels and incidents for every shift every day, making sure the right staffing skill mix was available to meet patients' needs. The planned number of nursing and care staff was displayed, alongside the actual number of staff present in the area each day. The staffing data was scrutinised by the trust board monthly and published on the trust website. The trust also carried out a review of staffing levels every six months and reported this to the board.

The department was able to staff its' paediatric bays with two registered children's nurses per shift as per national guidance, but did not have enough staff to cover any sickness or other absence such as planned leave. The department mitigated this by offering appropriate training to adult nurses to enable them to build the appropriate skills and experience to treat children.

The children's ward within the hospital supported their colleagues in the emergency department and provided additional staff to assist within the department when necessary. Staff we spoke with confirmed this.

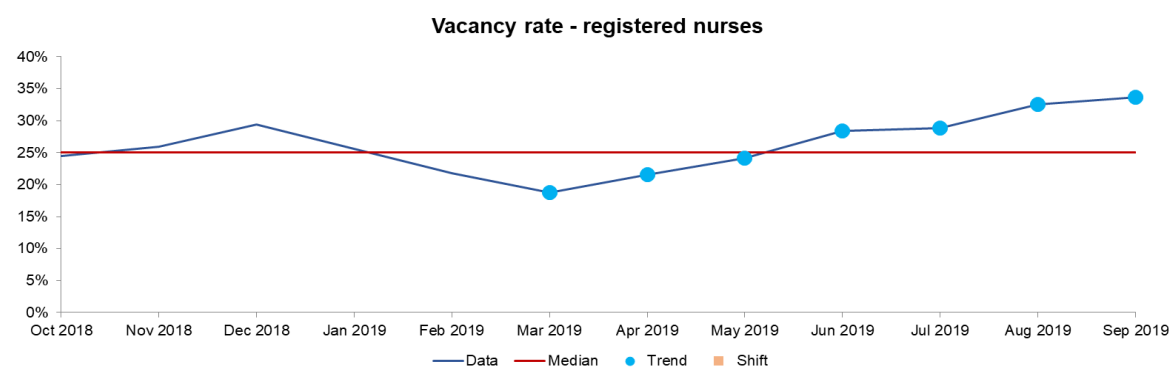
The table below shows a summary of the nursing staffing metrics in urgent and emergency care at Royal Hampshire County Hospital compared to the trust's targets, where applicable:

	Urgent and emergency care annual staffing metrics						
	October 2018 to September 2019						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	127	31%	8%	5.7%			
Registered nurses	73	27%	6%	4.6%	18,277 (14%)	29,611 (23%)	2,103 (2%)

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

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

Vacancy rates



The clinical matron adjusted staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers. At the time of the inspection the emergency department had 24 nurse vacancies. Gaps in the roster were filled with competent bank or agency staff.

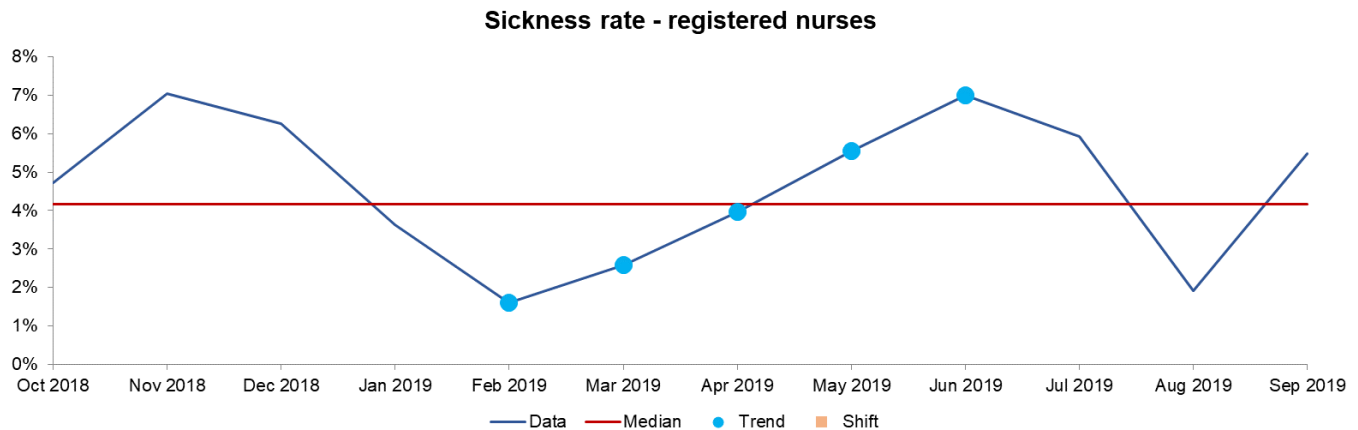
Monthly vacancy rates over the last 12 months for registered nurses show an upward trend from

March 2019 to September 2019. This was because there had been an agreed uplift in staffing numbers and recruitment was ongoing.

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

Sickness rates

The service had low and/or reducing sickness rates.

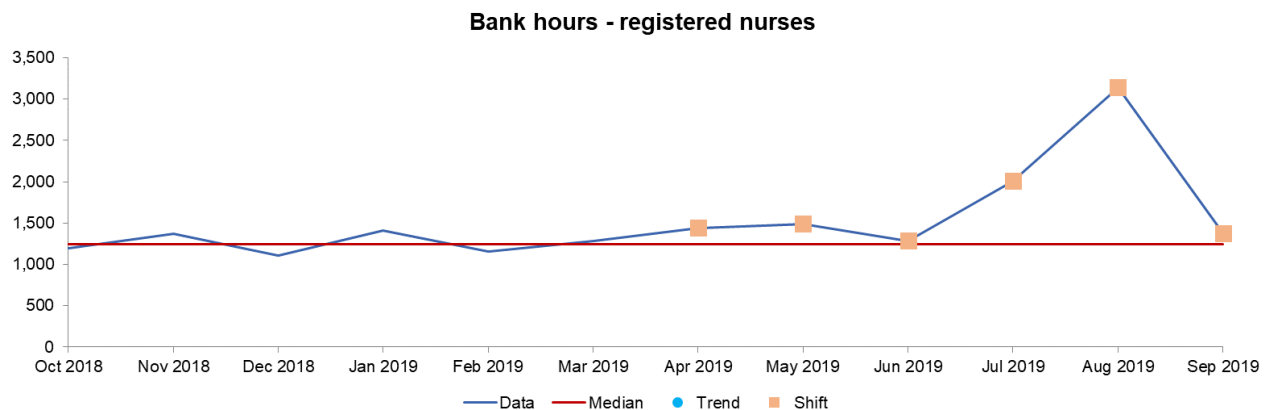


Monthly sickness rates over the last 12 months for registered nurses show an upward trend from February 2019 to June 2019. This could be an indicator of deterioration.

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

Bank staff usage

The service had low and/or reducing rates of bank and agency nurses.



Monthly bank use over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019. This reflected what staff told us; recruitment was ongoing and new staff were supernumery until fully competent and familiar with the department routines.

Bank staff also supported the permanent staff when there were gaps in the rosters. Managers limited their use of bank and agency staff and requested staff familiar with the service. All bank and agency staff completed the same departmental induction process as permanent staff which included observed practice to assess competency.

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

Medical staffing

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

The service had enough medical staff to keep patients safe. Consultants worked in both the Basingstoke and Winchester sites and provided cover in accordance with Royal College of Emergency Medicine (RCEM) recommendations.

Trust level

The table below shows a summary of the medical staffing metrics in urgent and emergency care at trust level compared to the trust's targets, where applicable.

	Urgent and emergency care annual staffing metrics						
	October 2018 to September 2019						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual locum hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	432	14%	16%	4.7%			
Medical staff	126	-5%	33%	0.7%	17,861 (15%)	10,847 (9%)	

The staffing analysis below includes staff working across all sites.

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

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

Vacancy rates

The service had low and/or reducing vacancy rates for medical staff.

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

One emergency medicine consultant explained that medical staffing was on the local risk register, due to the low number of middle grade doctors (3). Increased consultant presence, flexibility between the two hospital sites and use of regular locum staff ensured safe levels of medical cover. The service was making a lot of effort to ensure these highly skilled doctors were competent. They were offered extra training opportunities. For example, advanced paediatric life support (APLS) training and human factors training. All middle grades were encouraged to share

their skills to support and train others, for example one of the team was an ultrasound specialist. The service was developing two fellowship posts at the time of the inspection. These were to support quality improvement projects.

Turnover rates

The service had low and/or reducing turnover rates for medical staff.

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

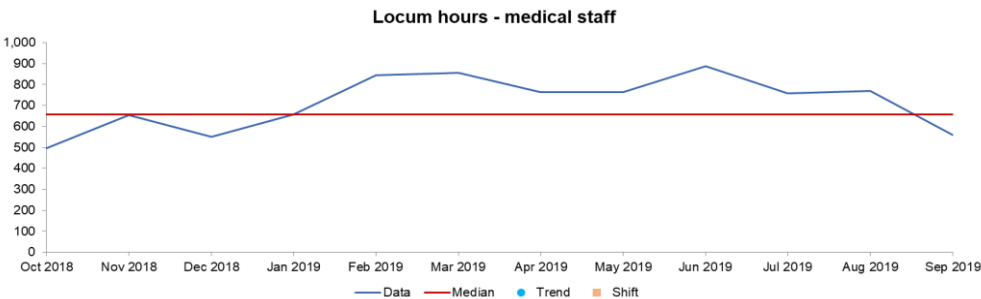
Sickness rates

The service had low and/or reducing sickness rates for medical staff.

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

Bank and locum staff usage

The service had low and/or reducing rates of bank and locum staff.



Monthly agency use over the last 12 months for medical staff show a downward shift from April 2019 to September 2019.

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

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. The new induction app for junior doctors gave new staff access to mandatory training modules and the department standard operating procedures in advance.

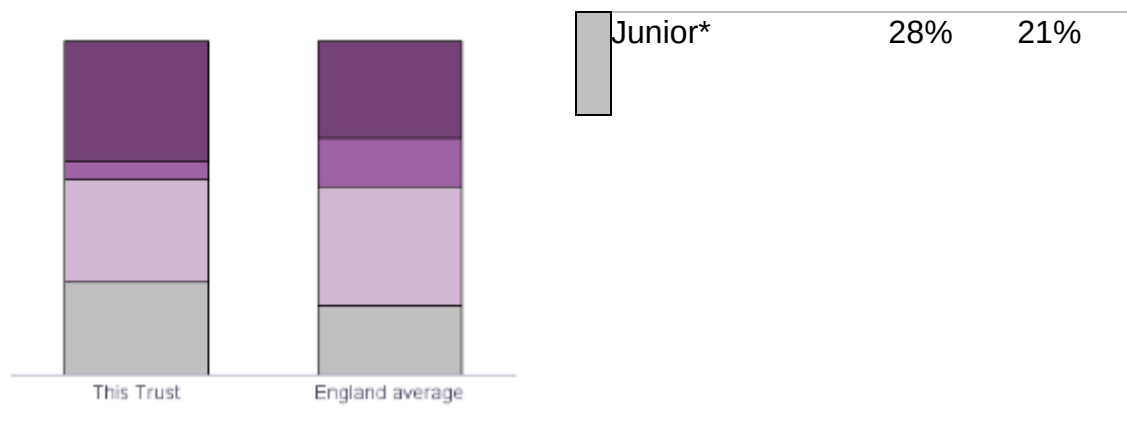
Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

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

Staffing skill mix for the 40 whole time equivalent staff working in urgent and emergency care at Hampshire Hospitals NHS Foundation Trust

	This Trust	England average
Consultant	36%	29%
Middle career^	6%	15%
Registrar group~	30%	36%



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

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

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

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

All patient records within the department were available electronically which ensured timely access. We observed staff logging out appropriately between patients. This meant that other specialities were able to access them in a timely manner.

We saw risk assessments such as early warning scores and pressure area care being completed appropriately and within the required timescales.

We reviewed patient discharge summaries and all were comprehensive. Discharge summaries were shared by the provider with other relevant professional such as GPs and care homes.

Staff were able to tell us that they would communicate information such as a patient requiring end of life care to the GP; we saw no examples of this during the inspection. Staff told us that they would telephone and follow up with emails to the patient's GP.

We saw that patient records contained details of other nonphysical conditions such as mental health needs and hidden disabilities. Staff were confident patient records contained all the information they required.

The department completed monthly audits of the emergency department checklist to ensure compliance and to maintain oversight. The audits for April 2019 to September 2019 saw compliance in excess of 90%.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines cupboards were clean, tidy with contents all in date. We saw staff clearly labelled products with a limited shelf life that were open with the date of opening.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Fridges were not overstocked, and temperatures were monitored and found to be correct. Staff knew what to do if they found that the temperatures were not correct.

The service stored controlled drugs safely and securely with access by authorised staff only. Staff completed weekly stock checks and a member of staff in the pharmacy department undertook a stock check every six months. We saw that staff disposed of medications correctly to the pharmacy department and staff recorded this was properly. However, we noted that the order book 'received by' section was seldom completed, which was a potential risk should some contents be absent.

Staff reviewed patient's medicines regularly providing specific advice to patients and carers about their medicines; and followed current national practice to check patients had the correct medicines.

Decision making processes were in place to ensure patients behaviours were not controlled by excessive and inappropriate use of medicines. The staff followed a six-step process when rapid tranquilisation of a patient was necessary which included use of medical sedation. There was a clear laminated procedure available to guide staff through the procedure.

During our inspection we found some Patient Group Directions (PGDs) were out of date. Staff told us that these were not in current use and staff were aware of this. A PGD is a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

We found that staff did not monitor the use of FP10 prescriptions thoroughly; there were two pads in use at a time and it was not clear that staff could audit these effectively and be sure they were not misused. The FP10 is a prescription that can be issued by a GP, nurse, pharmacist prescriber, supplementary prescriber or a hospital doctor in England.

Incidents

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

Staff knew what incidents to report and how to report them. Staff were able to describe what constituted an incident and they used an electronic system for all incident reporting. Staff told us there was a no blame culture and incident reporting was encouraged by senior leaders.

A senior nurse took the lead for reported incidents in the department. Pressure ulcers were the most reported incidents. As a result of this finding, all the mattresses in the department were changed to pressure relieving ones and staff reminded to plug these in to ensure they are always ready.

Falls were also reported regularly; the department had a detailed procedure available for staff to monitor patients who were a high falls risk and make them safe.

Managers investigated incidents thoroughly using root cause analysis methods of investigation. We saw examples of incident investigations carried out by staff which were detailed and included who was to take responsibility for apologising to the patients and their families where indicated,

Senior staff met to discuss the feedback and look at improvements to patient care. We saw

incidents were a standard agenda item for the governance meetings across the multidisciplinary team, where learning from incidents was discussed and shared.

The trust produced a monthly newsletter 'Learning from Events' which highlighted incidents that had happened around the trust. The document described staff experiences, actions to prevent recurrence and shared learning. Minutes of meetings of consultants, band 7 and band 6 nursing staff did not show that incidents which occurred in the emergency department were discussed at those meetings. This meant that opportunities for learning could be missed.

Managers debriefed and supported staff after any serious incidents and learning was shared with the teams at the handovers throughout the day.

All staff we spoke with were aware of the duty of candour regulation and how it should be applied. Investigation reports provided by the trust included actions to ensure this responsibility was recognised and allocated to someone to carry out. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Never events

From December 2018 to November 2019, the trust did not report any never events for urgent and emergency care.

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

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2018 to November 2019.

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

Incident type	Number of incidents	Percentage of total
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	2	28.6%
Treatment delay meeting SI criteria	2	28.6%
Abuse/alleged abuse of child patient by staff	1	14.3%
Slips/trips/falls meeting SI criteria	1	14.3%
VTE meeting SI criteria	1	14.3%

Total	7	100.0%

(Source: Strategic Executive Information System (STEIS))

Royal Hampshire County Hospital

In accordance with the Serious Incident Framework 2015, Royal Hampshire County Hospital reported two serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2018 to November 2019.

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

Incident type	Number of incidents	Percentage of total
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	50.0%
Slips/trips/falls meeting SI criteria	1	50.0%
Total	2	100.0%

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

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

Safety thermometer data was displayed on wards for staff and patients to see.

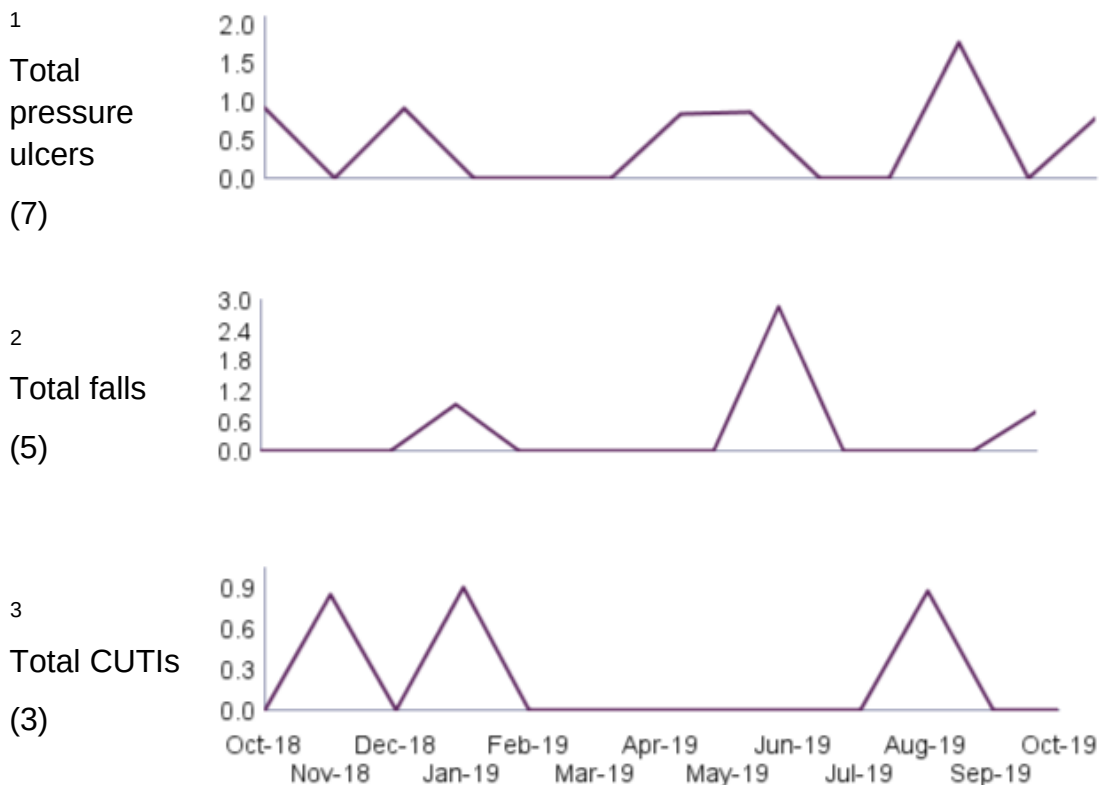
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

The safety thermometer data showed the service achieved harm free care within the reporting period. Staff used the safety thermometer data to further improve services.

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

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

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



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

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

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Staff delivered care, treatment and support was in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) and other expert professional bodies to meet both physical and mental health needs. . The emergency department used a combination of NICE and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment provided.

A range of clinical care pathways and proformas had been developed in accordance with national guidelines. These included, among others treatment of stroke, sepsis, asthma, fractured neck of femur. Staff assessed older people's needs using a frailty scoring system. When needed, the staff could access advice from the hospital frailty team. We found these were being used effectively to manage patients' care and treatment.

Policies relating to mental health were available. The mental health lead consultant and a band 7 lead nurse worked together in the emergency department to make sure their policies were up to date with best practice and included a standard operating procedure for the management of

patients with mental health needs.

The mental health lead consultant represented the emergency department on the mental health, capacity and learning disability committee. The committee met every two months; recent discussions appertaining to the emergency department included updating the restrictive practices policy, and an environmental review of the area outside the emergency department following two serious incidents highlighting the unsuitability of the space.

A programme of multidisciplinary audits was used to check care and treatment was being provided in accordance with national guidelines. Where performance could be improved, action plans were completed, and learning was shared with staff.

There was a GP in the department one day a week to audit all the care provided to ambulatory patients, using data to inform healthcare professionals if attenders could be treated more effectively elsewhere.

Staff managed patient violence and aggression in line with trust guidance. Staff received training, and policies were available to support staff in managing violence and aggressive behaviours from patients. Security staff also received training in how to manage aggressive situations.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink. Vending machines were available in the waiting area providing snacks and drinks. Housekeepers supported the clinical staff to provide sandwiches, milk and biscuits or hot meals when necessary.

There were prompts within the safety checklist to remind staff to consider patients' hydration and nutrition needs. Records we reviewed showed staff made sure this was considered and documented.

Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 6.9 for the question "Were you able to get suitable food or drinks when you were in A&E?". This was the same as other trusts.

(Source: Emergency Department Survey 2019)

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools.

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used the Abbey pain scale to assess the pain levels of patients living with dementia or who could not communicate verbally. The Abbey Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs, for example, patients with dementia, cognition or communication issues.

We saw age specific observation charts for children which included a section for the assessment of pain scores on a numerical range from 0-10 for 1-4 year olds, 5-12 years and 13-18 years. There was also a pain section on the PEWS (paediatric early warning score) charts.

Patients told us they received pain relief soon after requesting it, and records showed staff prescribed, administered and recorded pain relief accurately.

Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 7.5 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

(Source: Emergency Department Survey 2019)

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved variable outcomes for patients.

The service participated in relevant national clinical audits. The clinical effectiveness lead told us that during the previous 18 months when so many changes were taking place in the emergency departments the focus had been on developing new standard operating procedures and care pathways with smaller quality improvement projects to support the new ways of working.

The department had focussed on improving the management of sepsis during the year and regular audit of practice and documentation showed an improving trajectory through the year.

The RCEM audits restarted in 2018/19 were; feverish children, thrombo-prophylaxis, and vital signs which tied in with the ongoing NEWS2 and VTE audits. The plan for 2019/2020 was to contribute to the national audits for mental health, assessment of cognitive impairment, and care of children in the emergency department.

RCEM Audit: Moderate and acute severe asthma 2016/17

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital’s performance in the 2016/17 RCEM moderate and acute severe asthma audit.

The audit reports hospital performance in quartiles. In this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results nationally.

Metrics (Audit measures)	Hospital performance	Comparison to other Hospitals	Met national standard?
Standard 1a: O2 should be given on arrival to maintain sats 94-98%.	16.0%	Similar	Not met
Standard 2a: Vital signs should be measured and recorded on arrival at the emergency department.	38.0%	Similar	Not met
Standard 3:	30.0%	Similar	Not met

High dose nebulised β 2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department.			
Standard 4: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β 2 agonist bronchodilator therapy.	95.7%	Better	Not met
Standard 5a: If not already given before arrival to the emergency department, steroids given within 60 minutes of arrival (acute severe).	61.1%	Better	Not met
Standard 5b: If not already given before arrival to the emergency department, steroids given within four hours of arrival (moderate).	81.3%	Better	Not met
Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines.	0.0%	Worse	Not met

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the 2016/17 RCEM consultant sign-off audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics (Audit measures)	Hospital performance	Comparison to other Hospitals	Met national standard?
Percentage of patients from high-risk groups reviewed by a consultant in Emergency Medicine prior to discharge from the Emergency Department:			
Atraumatic chest pain in patients aged 30 years and over.	Not reported	N/A	N/A
Fever in children under 1 year of age.	Not reported	N/A	N/A
Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge.	0.0%	Worse	Not met

Abdominal pain in patients aged 70 years and over.	Not reported	N/A	N/A

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the 2016/17 RCEM Severe sepsis and septic shock audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics (Audit measures)	Hospital performance	Comparison to other Hospitals	Met national standard?
Standard 1: Respiratory rate, oxygen saturations (SaO ₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival.	12.0%	Worse	Not met
Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED.	92.0%	Better	Not met
Standard 3: O ₂ was initiated to maintain SaO ₂ >94% (unless there is a documented reason not to): Within one hour of arrival.	38.5%	Similar	Not met
Standard 4: Serum lactate measured: Within one hour of arrival.	62.0%	Similar	Not met
Standard 5: Blood cultures obtained: Within one hour of arrival.	54.0%	Similar	Not met
Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival.	40.8%	Similar	Not met
Standard 7: Antibiotics administered: Within one hour of arrival.	48.0%	Similar	Not met

Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival.	50.0%	Better	Not met

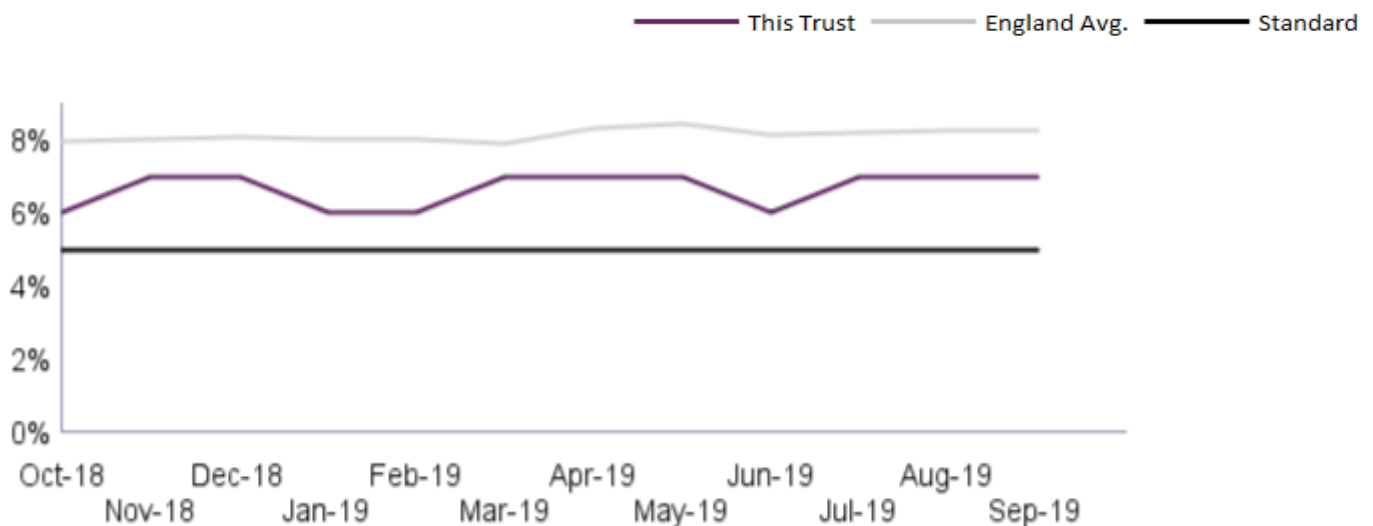
(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within seven days

The service had a lower than expected risk of re-attendance than the England average.

From October 2018 to September 2019, the trust's unplanned re-attendance rate to A&E within seven days was consistently higher than the national standard of 5% although it was lower (better) than the national aggregate over the same time period.

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



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

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. A high number of new staff had joined the team in the emergency department of the Royal Hampshire County Hospital and individual development programmes were developed to support them. Managers gave all new staff a full induction tailored to their role before they started work. Staff told us that they received short appraisals at 10 weeks and 20 weeks to ensure they were settling in and that their induction programme continued to be appropriate to their needs.

All staff were given opportunities to complete non-mandatory training to improve their skills and experience.

The clinical matron told us the department had been funded for a fulltime nurse clinical educator from March to support the learning and development needs of staff. When managers identified any training needs they usually gave staff the time and opportunity to develop their skills and

knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. The trainee emergency nurse practitioners and the advanced clinical practitioners accessed a local training programme and their development was monitored through the appraisal system.

Junior doctors had access to policies and training modules before they arrive

New staff who had joined the department from overseas were all enrolled onto the five week OSCE (Objective Structured Clinical Examination) programme, which concluded with an examination. The OSCE is designed to assess an individual's ability to competently apply their professional nursing or midwifery skills and knowledge in the UK. It is set at the level expected of nurses and midwives as they enter the profession (at the point of registration). Recently appointed staff told us they had been supernumery for three weeks and training courses were available to them straight away. One band 5 nurse explained they had been in post 18 months and they were working through the Royal College of Nursing Emergency Care Association National Curriculum and Competency Framework and was at level 2.

The matron told us that the biggest skills gap in the department at the time of our inspection was in safeguarding children level 3. Nurses trained in adult health and care were undertaking training in basic skills in paediatric care in order to ensure there were enough trained staff to support the paediatric team in the department. This ensured they are familiar with working practices when they started work.

Staff had opportunities for one to one meetings, appraisals and support with revalidation. Senior staff were able to describe the performance management process which allowed opportunities for staff to improve. Examples of support were supernumerary work and observed practice.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

As at September 2019, 91.9% of staff within the urgent and emergency care core service at the trust received an appraisal compared to a trust target of 90%.

Trust level

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add prof scientific and technic	1	1	100.0%	90%	Yes
Allied health professionals	1	1	100.0%	90%	Yes
Nursing and midwifery registered	145	153	94.8%	90%	Yes
Administrative and clerical	47	51	92.2%	90%	Yes
Additional clinical services	71	79	89.9%	90%	No
Medical and dental	31	37	83.8%	90%	No
Total	296	322	91.9%	90%	Yes

Royal Hampshire County Hospital

As at September 2019, 97.8% of staff within the urgent and emergency care core service at Royal Hampshire County Hospital received an appraisal compared to a trust target of 90%.

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Administrative and Clerical	18	18	100.0%	90%	Yes
Nursing and Midwifery Registered	58	58	100.0%	90%	Yes
Additional clinical services	13	15	86.7%	90%	No
Total	89	91	97.8%	90%	Yes

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

Multidisciplinary working

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

Ambulance staff worked with the department's staff to ensure patient safety. We observed the staff working together to prioritise and support patients.

Staff could make referrals to local support services for drug and alcohol dependency. There was a close working relationship with the specialist teams at a nearby community health trust.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was good multidisciplinary working between the department and psychiatry liaison services. Staff attended handovers to ensure a department wide understanding of the pressures and to enable early identification of patients. Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We saw the psychiatry liaison services attending the department and working with staff to ensure the patients best interests were being met.

The local child and adolescent mental health service (CAMHS) were available to staff through the paediatric team on Northbrook ward.

We saw security staff patrol the department and staff told us when needed they could rely on security staff to arrive promptly. We spoke with security staff who confirmed they had undertaken training in restraint practice. The course included: hospital factors that increase the risk; natural effects; a safe approach; during confrontations - leaving a situation; use of reasonable force.

We saw the hospital in-reach team attend the department daily and more often if required. Their role was primarily to support unnecessary admissions to hospital by assessing patients' needs and referring to other healthcare professionals such as the occupational therapists and the frailty team.

The staff worked closely with the site co-ordinators who supported the teams throughout the hospital to find the beds in the right speciality for patients requiring admission.

Seven-day services

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

The emergency department had a range of services seven days a week at Royal Hampshire County Hospital.

The adult and children's departments provided services in line with the NHS seven-day services clinical standards. Nurses and medical staff provided cover over 24 hours a day, seven days a week. This was either on site or on-call. Junior and middle-grade doctors told us the consultants were always accessible and gave them good support and would attend when they were on call as required.

Pharmacy services were available either in the department, accessible by telephone or on call. Staff told us should they need specific medicines not stocked in the department, the pharmacy responded in a timely way.

The department was located close to the diagnostic imaging department and had rapid access to CT scanning facilities as required. The imaging services were available 24 hours a day, seven days a week.

The psychiatric liaison team for adults was available 24 hours a day seven days a week. However, the child and adolescent mental health service (CAMHS) team were available Monday to Friday between 9am and 5pm.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on display in the waiting areas, such as smoking cessation, how to contact relevant support networks and information specifically designed for children of different ages. However, we only saw literature in English but staff told us they had access to information in other languages.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. We observed staff giving health promotion advice to patients and we saw examples of this recorded in paediatric notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the mental capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed records and saw staff clearly recorded consent in the patients' records.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All the staff we spoke with told us they had training in the MCA and DoLS, though data received from the trust showed staff in the emergency department had not met the trust

target for non-medical clinical staff. Staff sought advice on the mental capacity act and about questions relating to a patient's capacity to make decisions from senior clinicians, if they were unsure.

Staff told us when patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions, and made sure patients consented to treatment based on all the information available.

Mental Capacity Act and Deprivation of Liberty training completion

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at trust level for registered nursing staff in urgent and emergency care is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	134	170	78.8%	90%	No

In urgent and emergency care the target was not met for MCA/DoLS training modules for which registered nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	52	74	70.3%	90%	No

In urgent and emergency care the target was not met for MCA/DoLS training modules for which medical staff were eligible.

Royal Hampshire County Hospital

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Royal Hampshire County Hospital for registered nursing staff in urgent and emergency care is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	50	62	80.6%	90%	No

In urgent and emergency care the target was not MCA/DoLS training modules for which registered nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Royal Hampshire County Hospital for medical staff in urgent and emergency care is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	20	22	90.9%	90%	Yes

In urgent and emergency care the target was met for MCA/DoLS training modules for which medical staff were eligible.

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff introducing themselves by name and role and talking with patients in a friendly way. We observed staff using curtains to protect patient dignity in the bays.

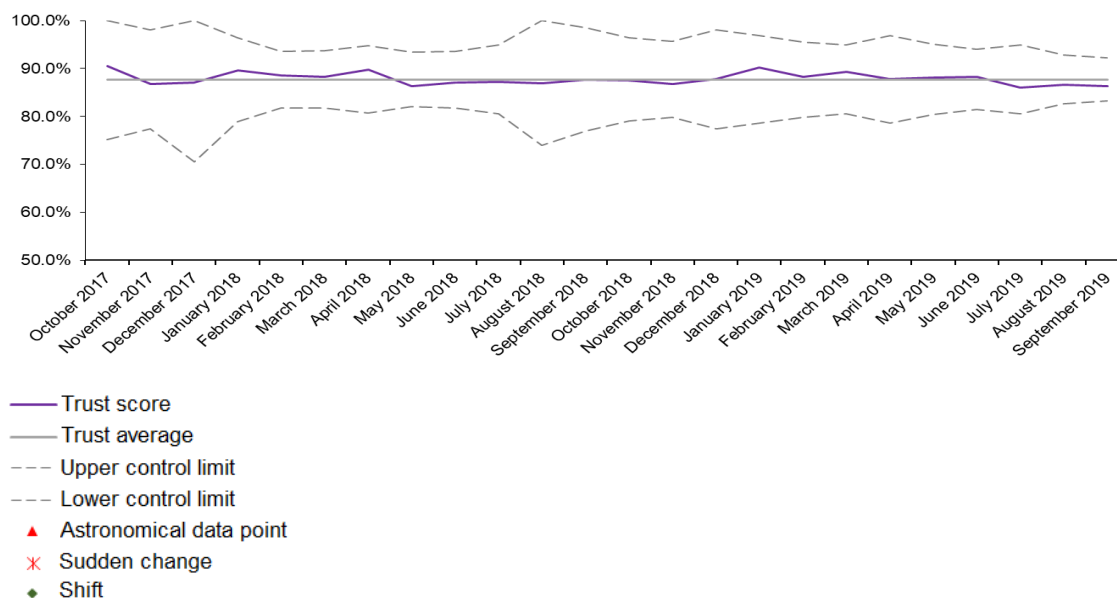
Patients said staff treated them with kindness. All patients we spoke with said staff really seemed to care about them and staff were always friendly and approachable. A patient said staff were always thoughtful and often asked about home and family as well. Another patient was pleased staff asked what they would like to be called or how they would like to be addressed.

Staff understood and respected the individual needs of each patient. Staff showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs, learning disabilities, autism or dementia. Care records indicated staff knew how to support people in a mental health crisis. Records showed sensitivity and understanding of patients. A patient we spoke with said staff were kind and treated them like a person and not a number on a board.

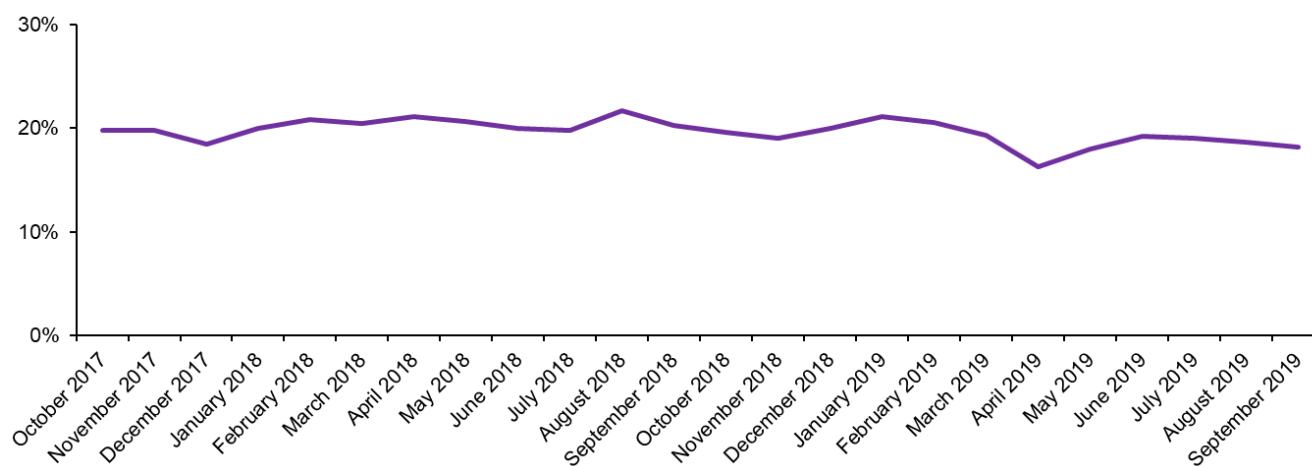
Friends and Family test performance

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 86.0% and 90.5% from October 2017 to September 2019. There wasn't as much variation in the FFT scores as might be expected over time.

Friends and family test performance – Hampshire hospitals NHS Foundation Trust – October 2017 to September 2019



Hampshire Hospitals NHS Foundation Trust – response rate October 2017 to September 2019



(Source: Friends and Family Test – NHS England)

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients knew how to seek help and said they felt listened to. We observed patients approaching staff for support and staff responding courteously.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a patient in major treatment area who was distressed; the department staff were kind and attentive. They gave reassurance every few minutes and gave guidance and updates to the patient and their relative at every opportunity. The staff we spoke with told us the patient needed to be in the line of sight of the nurses' station. We observed staff talking with the patient and speaking calmly with a soft voice which seemed to help the patient to relax in the environment.

Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them. Staff encouraged patients to maintain contact with their relatives and supported patients to get in touch with relatives when needed. We observed staff spending additional time talking with a patient who had recently lost a loved one. The staff showed genuine interest and the patient subsequently told us they felt safe and supported.

Chaplaincy services were available at this location 8am-10pm seven days a week. Outside of these hours, the chaplaincy service provided an on-call service. The hospital chapel/faith rooms were available to patients and staff at all times.

Understanding and involvement of patients and those close to them

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

We saw staff giving explanations to people who arrived in the department about what would happen next, information about any delays in the department and what the patient could expect.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with said staff kept them updated and involved at every stage of their treatment. A patient told us staff took extra time to listen to and answer their relative's concerns and questions. Most patients told us when they had received results from imaging and blood tests, staff had explained what results meant and what the next options were.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients told us they felt confident to feedback and had felt encouraged to do so by staff.

Urgent and Emergency Care Survey 2018

The feedback from the 2018 Emergency Care Survey was positive. The trust scored about the same as other trusts for all 24 survey questions relevant to the caring domain in the Urgent and Emergency Care Survey 2018.

Emergency Department Survey 2018 – Type 1 A&E departments

The feedback from the Emergency Department survey test was positive.

The trust scored worse than other trusts for one of the 26 emergency department survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 25 questions.

Question	Trust score	RAG
Q10. Were you informed how long you would have to wait to be examined?	4.1	About the same as other trusts
Q11. While you were waiting, were you able to get help from a member of staff to ask a question?	7.8	About the same as other trusts
Q13. Did you have enough time to discuss your condition with	8.9	About the

Question	Trust score	RAG
the doctor or nurse?		same as other trusts
Q14. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.6	About the same as other trusts
Q15. Did the doctors and nurses listen to what you had to say?	9.0	About the same as other trusts
Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.9	About the same as other trusts
Q18. Did doctors or nurses talk to each other about you as if you were not there?	9.1	About the same as other trusts
Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?	8.4	About the same as other trusts
Q21. While you were in A&E, how much information about your condition or treatment was given to you?	9.0	Worse than other trusts
Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.1	About the same as other trusts
Q24. Sometimes, a member of staff will say one thing, and another will say something quite different. Did this happen to you?	8.9	About the same as other trusts
Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.2	About the same as other trusts
Q45. Overall, did you feel you were treated with respect and dignity while you were in A&E?	9.0	About the same as other trusts
Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.5	About the same as other trusts
Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.6	About the same as other trusts
Q28. Before you left A&E, did you get the results of your tests?	8.5	About the same as other trusts

Question	Trust score	RAG
Q29. Did a member of staff explain the results of the tests in a way you could understand?	8.8	About the same as other trusts
Q30. If you did not get the results of the tests when you were in A&E, did a member of staff explain how you would receive them?	6.4	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.5	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	5.5	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	6.1	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving A&E?	6.1	About the same as other trusts
Q42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	7.2	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?	8.0	About the same as other trusts
Q44. Did staff give you enough information to help you care for your condition at home?	8.3	Better
Q46. Overall... (please circle a number)	8.2	About the same as other trusts

(Source: Emergency Department Survey 2019)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Facilities and premises were appropriate for the services being delivered. Once in the department the signage to direct patients was clear enough to be understood by people who were unfamiliar with the environment. This information clearly displayed to patients the area they were in, and

what to expect from each stage and area of the department. The reconfiguration of the area in April 2019 had been well thought out and was working well for the staff and patients.

Escalation procedures were responsive when the department experienced capacity issues. The emergency department monitored the attendance data to help with service planning. The departments used a predictor tool to review the same level of activity 12 months previously to identify how the department may run that day. Staff rotas had been adapted to meet demand. Following a review of the number of attendances and the type of patients and when these attendances occurred, changes were made to reflect this.

The department was developing roles to meet the needs of patients. The service relieved pressure on other departments when they could treat patients in a day. A same day emergency care (SDEC) area had recently opened which was run by advanced practice nurses. The service was available between the hours of 8am and 6pm six days a week. We observed practice and found it to be an effective and efficient way to safely manage demand.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw there were resources available to meet the individual needs of patients living with dementia which included a resource trolley in the department. There were dementia champions in the department who told us they were fully supported by the hospital dementia leads.

There was a mental health assessment room available which was ligature free and a suitable, safe space for adults and children. The room was also used as a private space when required.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. The service had systems to help care for patients in need of additional support or specialist intervention. Staff told us they were able to rely on extra staff to look after patients on a one to one basis when necessary. Staff could access mental health records for adults to check whether patients had an existing mental health condition.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. 'This is me' is a document designed to support people with communication difficulties or cognitive impairments when they are in an unfamiliar place. It provides a 'snapshot' of their background, personal habits and likes or dislikes. These documents were available in the emergency department and staff were familiar with them. There was an activity box stored in the department which contained a range of resources, including tactile objects which could be used to occupy and distract patients, who may be anxious.

Staff understood and applied the policy on meeting the information and communication needs of patients with a sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. We saw from records that staff carried out regular checks to assess and manage the fundamental care needs of every patient.

The service had information leaflets available in languages spoken by the patients and local community. Alternative languages were not displayed but were available when required. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences, there was a housekeeper employed to look after this aspect of patient care.

Board rounds took place twice daily; all patients were seen and their care plans reviewed.

Emergency Department Survey 2018 – Type 1 A&E departments

The trust scored about the same as other trusts for the three emergency department survey questions relevant to the responsive domain.

Question – Responsive	Trust score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.0	About the same as other trusts
Q12. Overall, how long did your visit to A&E last?	7.3	About the same as other trusts
Q22. Were you given enough privacy when being examined or treated?	9.1	About the same as other trusts

(Source: Emergency Department Survey 2019)

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

We found that staff in the emergency department had worked extremely hard to improve their working practices to meet the demand on their service and had achieved a great deal. Patients had access to the service and received the right care or were directed to the right care. Flow of patients through the wider healthcare system affected the emergency department and this was reflected in the wait times data. The wait times were also affected by the work carried out on the fabric of the building. We did not have actual data for the number of attendances at the Royal Hampshire County Hospital, but all staff told us they felt that numbers had increased significantly in the previous two years.

Operational meetings took place twice a day or more frequently if needed. The department was represented by the emergency department operations manager and included the hospital site co-ordinators and representation from the wards. At the meeting, the trust's escalation status was confirmed, and bed pressures, expected transfers and admissions, and staffing were all discussed. Staff managed patients expected for admission in the emergency department, until a suitable bed was vacated. This was not always timely which meant patients remained in the emergency department longer than necessary.

We attended hospital bed meetings chaired by the director of the day. The meeting involved ward

staff verbally reporting on the number of potential discharges for each ward. At the first meeting we attended, ward staff reported a number of empty beds were available but there appeared to be no drive to take patients from the emergency department as a priority even though the department was very busy. There was not always an action plan to deliver more beds and there did not seem to be efficient use of the discharge lounge. At the next meeting, we saw staff arriving late and holding other conversations. This meant that staff did not appear to give their full attention to the meeting and were not necessarily able to provide up to date information on their bed capacity when asked. The impact could be that beds were not identified to allow patients to be transferred quickly out of the emergency department to the wards.

Emergency nurse practitioners were available to triage patients according to need and direct them to the care they needed according to their condition. The emergency nurse practitioner also identified which patients would be safe as 'fit to sit' patients, so their condition meant they could be treated in the fast flow area and did not need a bay. Pathways were established to ensure patients were seen and treated in a safe and responsive manner.

Delays for patients in the emergency department were often caused by wider hospital flow issues. We looked at what caused the delays for patients and saw multiple causes influenced the delays. Some were caused by delays in accessing in-patient beds. On both days of the inspection reasons for patients being delayed was caused by waiting for medical beds.

A further issue which caused queueing, were surges in ambulance arrivals. The normal peaks of activity in the emergency department were anticipated and staff were planned to meet these where possible. However, there were sometimes surges in demand caused by external factors which could not be anticipated. For example, ambulances may not be available at one time for a geographical area, so when there was capacity, a surge of activity took place. The emergency department had access to ambulance information to give them information of planned arrivals to the department. This enabled some advanced planning of capacity. We did not see this situation during our inspection.

Staff undertook 'reverse queueing' which was a process of prioritisation. This meant patients would wait on the corridor, and when a space became available in the department, they would be moved in. Any patients waiting for outcomes or treatment, and considered low risk, were moved back to the corridor. Staff risk managed this process for patient safety.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The in-reach team co-ordinated care with the frailty team in an attempt to discharge patients at the earliest opportunity and avoid hospital admission if safe to do so. Staff in the department followed processes to ensure these patients were cared for safely.

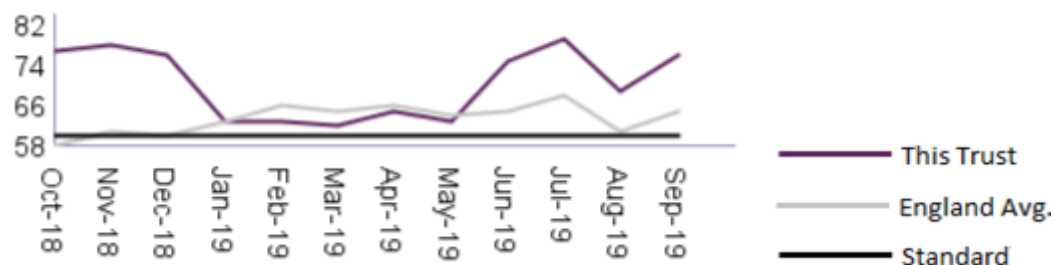
Median time from arrival to treatment (all patients)

Managers monitored waiting times and made sure patients could access emergency services when needed. Patients did not always receive treatment within agreed timeframes and national targets.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for any months over the 12-month period from October 2018 to September 2019. The trust's median time to treatment was especially lengthy compared with England between October 2018 and December 2018 and between June 2019 and September 2019. Reconfiguration of the

department had taken place in 2019 and new ways of working introduced. This was not yet embedded as some of the changes were very new at the time of the inspection.

Median time from arrival to treatment from October 2018 to September 2019 at Hampshire Hospitals NHS Foundation Trust



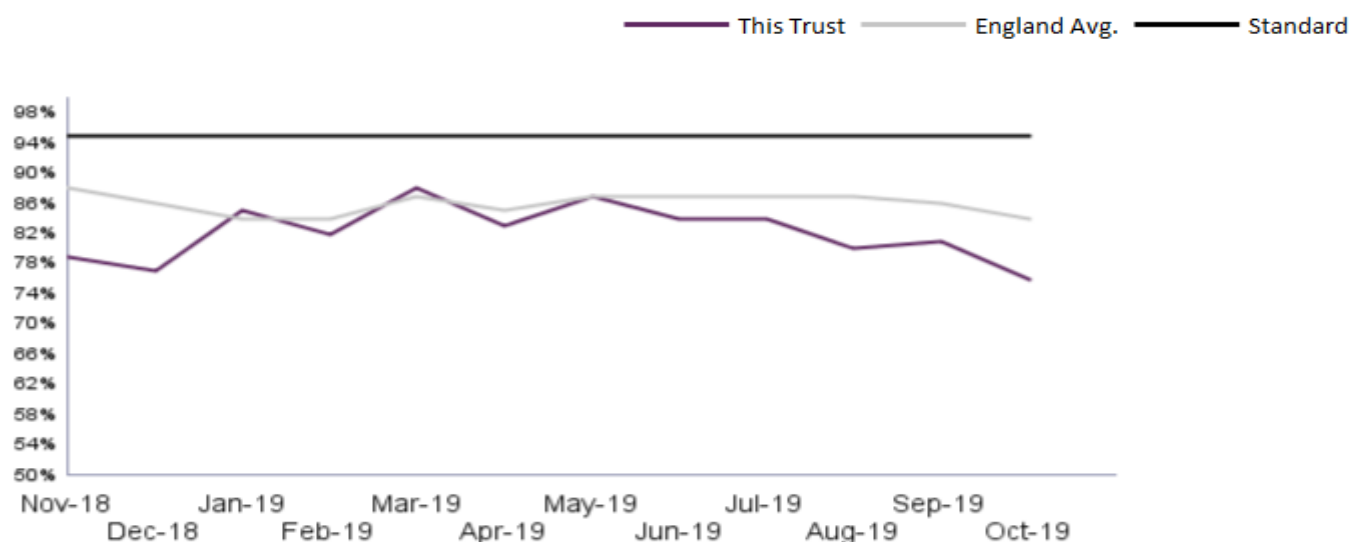
(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From November 2018 to October 2019 the trust failed to meet the standard and overall performed worse than the England average with performance worsening particularly from June 2019 onwards.

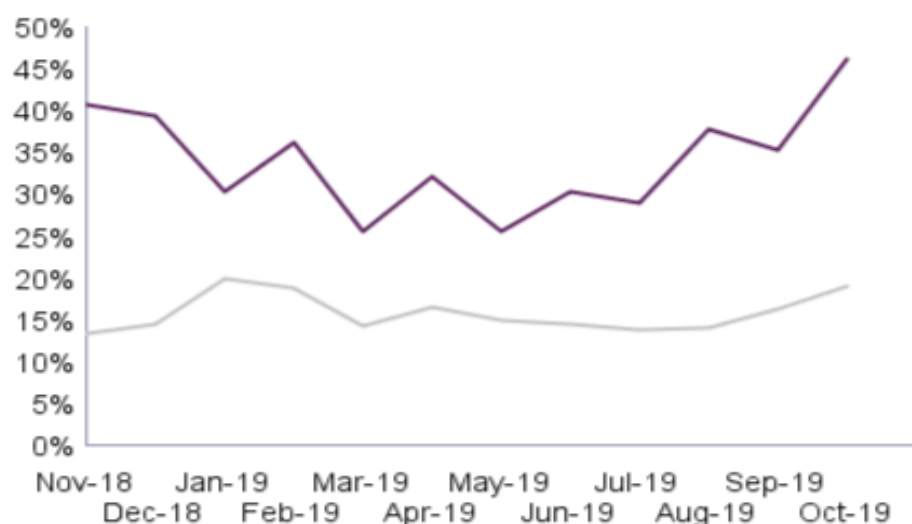
Four-hour target performance - Hampshire Hospitals NHS Foundation Trust



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

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

— This Trust — England Avg.



(Source: NHS England - A&E SitReps)

From November 2018 to October 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from November 2018 to October 2019, 29 patients waited more than 12 hours from the decision to admit until being admitted. The months with the highest number of patients waiting over 12 hours were November 2018, February 2019, April 2019 and October 2019.

Month	Number of patients waiting more than four hours to admission	Number of patients waiting more than 12 hours to admission
Nov-18	1,105	5
Dec-18	1,032	0
Jan-19	830	0
Feb-19	914	5
Mar-19	745	1
Apr-19	1,008	5
May-19	817	1
Jun-19	942	1
Jul-19	920	0
Aug-19	1,133	3
Sep-19	1,098	1
Oct-19	1,550	7

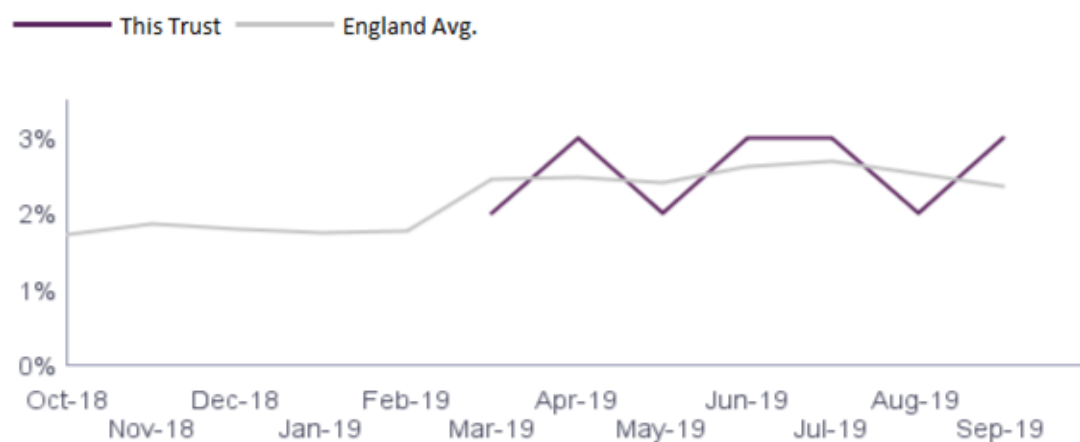
(Source: NHS England - A&E Waiting times)

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

The number of patients leaving the service before being seen for treatments was low.

From March to September 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was largely in line with the England average.

Percentage of patients that left the trust's urgent and emergency care services without being seen - Hampshire Hospitals NHS Foundation Trust



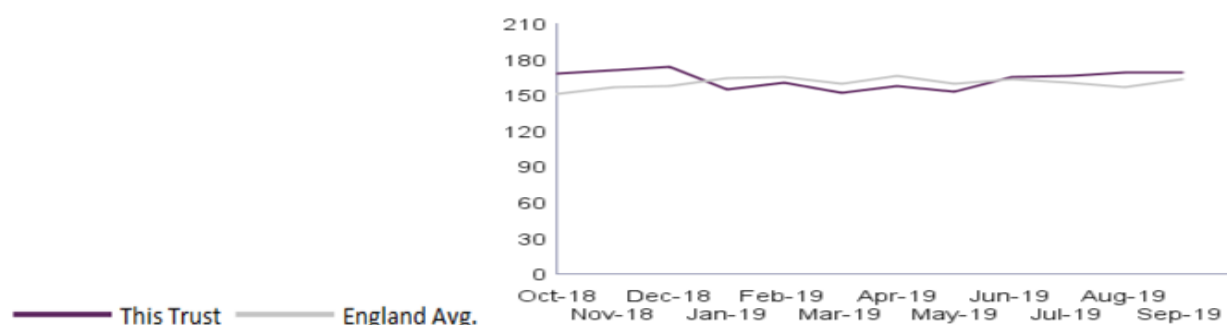
(Source: NHS Digital - A&E quality indicators)

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

From October 2018 to September 2019 the trust's monthly median total time in A&E for all patients was higher than the England average for seven out of 12 months.

Over the whole period total time spend in A&E at the trust ranged from 152 to 174 minutes, against an England average ranging from 151 to 166 minutes.

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



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

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Trust level

From October 2018 to September 2019 the trust received 130 complaints in relation to urgent and emergency care (17% of total complaints received by the trust). The trust took an average of 20.0 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be investigated and closed within 25 working days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	48	36.9%
Communication	18	13.8%
Values and behaviour	17	13.1%
Patient care	13	10.0%
Admissions and discharges	9	6.9%
Waiting times	7	5.4%
Trust admin/policies/procedures	6	4.6%
Other	3	2.3%
PDW	3	2.3%
Facilities	2	1.5%
Appointments	1	0.8%
Staff numbers	1	0.8%
Consent	1	0.8%
Access to treatment and drugs	1	0.8%
Total	130	100.0%

Royal Hampshire County Hospital

From October 2018 to September 2019 there were 48 complaints about urgent and emergency care at Royal Hampshire County Hospital. The hospital took an average of 24.1 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be investigated and closed within 25 days. A breakdown of complaints by type is below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	16	33.3%
Values and behaviour	7	14.6%
Admissions and discharges	7	14.6%

Communication	6	12.5%
Patient care	5	10.4%
Access to treatment and drugs	1	2.1%
Other	1	2.1%
Trust admin/policies/procedures	1	2.1%
Facilities	1	2.1%
PDW	1	2.1%
Appointments	1	2.1%
Waiting times	1	2.1%
Total	48	100.0%

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

Staff understood the policy on complaints and knew how to handle them. Staff worked to manage concerns before they became formal complaints. Staff initially tried to resolve the concerns locally, and if this was not possible the complainant was directed to the patient support and complaints team. Information about how to raise a complaint was available in leaflet form and was displayed in the waiting room.

Managers investigated complaints and identified themes. Learning from complaints was discussed at governance meetings, team meetings and, if safety related, during safety briefings. This was confirmed in minutes of governance meetings.

Number of compliments made to the trust

From October 2018 to September 2019 there were 66 compliments about urgent and emergency care at the trust. A breakdown of compliments by site is below.

Site	Number of compliments	Percentage of total
Royal Hampshire County Hospital	33	50.0%
Basingstoke and North Hampshire Hospital	31	47.0%
Andover War Memorial Hospital	2	3.0%
Total	66	100.0%

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

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service

for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department in the Royal Hampshire County Hospital was led by a clinical matron, a clinical lead who was a consultant in emergency medicine and an operational manager.

The trust appointed a head of international recruitment early in 2019, this was a new role to support staff recruited from overseas, some of whom joined the emergency department team during the year.

All senior leaders were able to articulate their understanding of the challenges to quality and sustainability. They had identified the actions required to address them. There was a clear leadership direction to meet the needs of the patients in a creative, cohesive and pragmatic way. Staff at all levels told us their strongest attribute was the supportive team working and good leadership. The leadership team were highly visible in the department and regularly worked clinically so had a clear understanding of the pressures the department faced.

The clinical matron had been employed by the hospital for a number of years and had been encouraged to progress her career, attend courses to advance her leadership skills which benefitted the whole team.

All staff told us that the senior leadership was visible and approachable and available. Staff told us they trusted the leadership team and found them supportive and approachable. Staff told us when problems arose, and trends were identified, the leadership team had an inclusive approach to solutions

Staff found the executive team, including the chief executive to be visible approachable and engaged, providing excellent support. Staff felt the executives understood the emergency department issues around capacity and flow and they now had significantly more insight into the importance of the emergency department as a front door to the hospital.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with input from staff.

The trust had an overarching set of values which were displayed on posters in corridors:

Compassion, caring about our patients and our staff

Accountable and responsible, always improving

Respect for all: colleagues, patients and their families

Encouraging and challenging each other to always do our best

The vision and strategy for the emergency department was developed with input from staff. There was a particular focus on developing staff and creating roles which ensured that optimum care was delivered for patients in an environment which was comfortable, efficient and met national standards for emergency departments. Reconfiguration of the emergency department premises in early 2019 had fulfilled expectations.

The staff were in a position to focus more on quality in their newly refurbished accommodation and told us they were committed to patient centred, quality, timely care for every patient, by everyone, every time. This was demonstrated by staff during our inspection.

Culture

Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

We found the culture of the department open and inclusive. Staff that we spoke to felt that they were valued and respected by their peers and leaders. We asked staff at all levels about the morale of the department and they all said that morale was good and they worked as a team. Staff felt supported in their work and there were opportunities to develop their skills and competencies, which were encouraged by senior staff.

There was a desire from all staff we spoke with to provide effective care and treatment to patients. We observed staff working well together and there were positive working relationships with the multidisciplinary teams. We spoke with the trust in-reach team and psychiatric liaison team during our visit, all told us how much they enjoyed their roles mainly due to the friendliness of staff and camaraderie in the emergency department.

There were cooperative, supportive and appreciative relationships amongst staff. They jointly recognised and celebrated others' successes with trust WOW awards. The WOW! Awards are a national award system that recognise outstanding customer service.

Staff told us they felt supported to raise concerns without fear of retribution. Some, although not all staff, were aware of the freedom to speak up guardian. All staff we spoke with felt there was culture in which it was safe to speak up.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance framework to support the delivery of good quality care which included regular governance meetings. The trust had a clear committee structure with reporting from department to division to the board. Governance overview meetings had a standardised agenda which included, for example, unexpected deaths and trends; complaints, concerns and compliments to include themes, learning and timeliness of response; mandatory training.

The department held governance learning meetings which took place each month alternating between the Winchester and Basingstoke sites. The emphasis was on learning and included: learning from serious incidents and less serious incidents documented in the electronic reporting system; learning from Friends and Family test; learning from risk register; learning from complaints; learning from national updates, and learning from improvement projects. The agenda also included all aspects of patient care and experience, staff experience, infection control, and staff training.

The learning meetings were open to all staff and notes were kept and available to those unable to attend. Staff could also keep up to date with learning via the governance learning boards in the department and the top ten tips board available at the daily board round.

These meetings fed into the monthly divisional board meeting which reviewed and monitored the performance report. The report took the form of a dashboard and included, for example, workforce status, top risks and mitigations and performance metrics.

Key messages from these meetings were cascaded to staff in a variety of meetings which included, consultants meetings, band 7 and band 6 nurse meetings, and 'quality review for patients in the emergency department' meetings

Monthly mortality and morbidity meetings were attended by the emergency medicine consultants and the leadership team. Individual doctors presented case studies with detailed analysis and areas for discussion, culminating in learning and actions to improve and prevent recurrence of mistakes.

We reviewed meeting minutes from all of the above meetings and all included actions with ownership.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Regular performance meetings were held at divisional level where senior staff discussed issues around performance and what actions could be taken to prevent reoccurrence.

Governance meetings were held on a monthly basis and we saw that risk, incidents, performance and complaints were fixed agenda items. We saw meeting minutes with incidents, complaints and feedback as fixed agenda items.

The department maintained and reviewed a risk register and the top items were discussed regularly. At the time of our inspection the top three risks were the four hour target, middle grade vacancies and changes in the junior doctors contract, nursing vacancies. All of which had action plans to mitigate the risk of these issues affecting patient care. Crowding in the department was regularly reviewed on the trust risk register. During our inspection at the Royal Hampshire County Hospital we did not see any crowding.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There were effective information systems, which provided real-time and retrospective reporting of performance, safety, risk and quality, including patient experience. Information was regularly reviewed and used to support continuous improvement. Attendance and performance data was used when looking at staffing levels and any restructures of the department.

There was real-time information recorded about activity and waiting times, which was constantly monitored by senior staff in the emergency department and the site management team. This provided data for a report around performance, which was monitored daily, weekly and monthly. This helped to identify the factors which contributed to waiting times and delays in care.

The data collected was used to inform the performance report which was shared and discussed at the divisional governance meeting.

There were sufficient computer terminals for medical and nursing staff to complete records. There was a large digital display monitor used at the nurses' station, so staff could see quickly who was

in the department, where they were located, their stage of care and the time in the department. Nurse co-ordinators used this information to support their management of the department and movement of patients onto the wards.

There were effective information governance processes and safeguards. Staff received information governance training and staff understood their responsibility to safeguard confidential data.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Patients were able to feedback verbally, through written feedback forms, email, and through a link to a survey on the trust website. Patients we spoke with told us they were listened to and encouraged to give feedback. One patient said a staff member had helped them to access the feedback section on the hospital website as they were struggling to find it for themselves.

The trust developed an action plan following the staff survey at the end of 2018 which was published before the end of February 2019. Whilst 92% of staff reported that they felt trusted to do their job, and 90% felt their role made a difference to patients. There were actions which included, for example, a zero-tolerance campaign and twice-yearly respect events to address concerns around bullying and harassment; a new appraisal system to include wellbeing and a values focus; establishment of a health and wellbeing committee.

Staff we spoke with felt able to raise concerns to senior staff and managers when they had concerns. They told us that they were encouraged to speak up when things were not right in order that changes could be made. A lot of changes had taken place in the department during 2019 which included new ways of working and new roles for nurses and practitioners. Staff felt included at all stages and appreciated the opportunities this afforded them.

Learning, continuous improvement and innovation

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

Staff felt involved in improvement processes. Staff considered there had been real change in the last 12 months which had a positive impact on the department.

There was a strong emphasis on education, audit research and quality improvement, and a proactive culture which encouraged and supported learning and innovative practice. There was a lead consultant for quality improvement and audit and they invited staff to lead projects and audits. Findings and achievements were regularly presented at safety meetings.

The staff had reached a place in the development of the department whereby they could acknowledge where improvement was still required and focus on projects to improve patient care further.

There were three successful bids from the emergency department for Wessex Health Education England quality improvement support fund in 2019

The department was developing two fellowships for quality improvement, one of which was focussed on developing the standard operating procedures.

New ways of working, such as the rapid assessment and treatment and the same day emergency care areas were recognised throughout the hospital as an improvement to patient care and flow.

The reconfiguration works to accommodate care for children provided a space which met expected standards and separation from the adult areas.

The service was looking at reducing waiting times for pregnant women attending the emergency department and had developed a direct referral pathway which went live in December 2019.

The trust had been awarded the RCEM award for clinical education in 2019 and the emergency department has been nominated for the 2020 Health Service Journal for improvement achievements.

The service had looked at innovative ways to improve staff recruitment. There had been successful international nurse recruitment. The emergency nurse practitioner roles and the advanced clinical practitioners were fully recruited to with a supporting local training programme.

The in-reach team together with the frailty team were working successfully to support hospital admission avoidance for patients who could be cared for better elsewhere.

Research is encouraged and we saw examples of some of the local research activity for example, the 'tired study' – looking at medical practitioners, revealed there was a need for recuperation and time to rest.

Medical care (including older people's care)

Facts and data about this service

The medical care service at Hampshire Hospitals NHS Foundation Trust provides care and treatment across 10 specialities: cardiology, diabetes and endocrinology, elderly care and stroke, gastroenterology, endoscopy, respiratory, neurology and rheumatology.

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

Basingstoke and North Hampshire Hospital:

Ward/unit	Number of beds	Services provided
E1	22	Gastroenterology and acute general medicine
E2	24	General medicine
E3	28	Respiratory and acute general medicine
E4	25	Diabetes, endocrinology and acute general medicine
F1	22	Acute elderly care
F2	18	Acute elderly care
F3	14	Acute elderly care
Cardiac/CCU	27	Inpatient cardiology
Isolation ward	7	General medicine
Lyford unit	4	Specialty specific day cases and infusions
Overton ward	25	Non-acute rehabilitation
Acute assessment unit (AAU)	14 (plus 9 trolleys)	Acute medical and frailty unit
Total	230 (plus 9 trolleys)	

Royal Hampshire County Hospital:

Ward/unit	Number of beds	Services provided
Clarke	24	Inpatient cardiology and stroke
Clifton	26	Acute elderly care
Freshfield	26	Delayed transfer of care ward
McGill	40	Ambulatory care, acute medical and frailty unit
Shawford	27	Respiratory and acute general medicine
Twyford	24	Hyper acute stroke unit
Victoria	27	Gastroenterology and acute general medicine
Wykeham	22	Acute elderly care
Total	216	

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 46,878 medical admissions from July 2018 to June 2019. A breakdown of these admissions by type can be found below:

- Emergency admissions – 25,173 (53.7%)

- Elective (i.e. planned) – 402 (0.9%)
- Day cases – 21,303 (45.4%)

Admissions for the top three medical specialities were:

- Gastroenterology – 17,153
- General medicine – 14,802
- Cardiology – 3,071

(Source: Hospital Episode Statistics)

This report details our findings following our inspection of Royal Hampshire County Hospital. During this inspection, we visited medical care ward areas, escalation areas, and the discharge lounge. We attended meetings including bed meetings, board rounds, and leadership and flow meetings.

We spoke with approximately 42 staff. This included divisional leaders, medical staff, nursing staff, therapists, pharmacy staff, the discharge team, the site team, and speciality nursing and clinical leads.

We spoke with 13 patients and five relatives to discuss their experience of the care and treatment they received.

We reviewed 14 patient records to review record keeping and consider specific areas of care and treatment. We also analysed other information, including data and trust documents.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to staff. However, there were some mandatory training courses where staff did not meet trust targets for updating these key skills.

Mandatory training was comprehensive and met the needs of patients and staff. Nursing staff mostly kept up-to-date with their mandatory training. Since the last inspection, the trust had set a new (higher) target of 90% for completion of mandatory training, except for 'information governance'; which remained at 95%. The trust had also set targets for medicine management and immediate life support.

Prior to our inspection, data received from the trust showed the trust target of 90% was met for only four of the 12 mandatory training modules for which nursing staff were eligible. Nursing staff did not meet the 95% trust target set for the module information governance. This was a slight improvement since our last inspection when the trust targets were not met for any of the mandatory modules.

A breakdown of compliance for mandatory training courses from April to September 2019 for nursing staff in medicine at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019	

	Staff trained	Eligible staff	Completion rate	Trust target	Target met (Yes/No)
Dementia awareness (including privacy and dignity standards)	198	206	96.1%	90%	Yes
Counter fraud	196	206	95.1%	90%	Yes
Health and safety (slips, trips and falls)	196	206	95.1%	90%	Yes
Equality and diversity	191	206	92.7%	90%	Yes
Information governance	185	206	89.8%	95%	No
Conflict resolution	181	206	87.9%	90%	No
Basic life support	175	202	86.6%	90%	No
Immediate life support	175	202	86.6%	90%	No
Moving and handling	178	206	86.4%	90%	No
Fire (1 year)	176	206	85.4%	90%	No
Infection control	162	206	78.6%	90%	No
Medicine management training	125	206	60.7%	90%	No

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

During the inspection, we requested the most recent data (December 2019) for mandatory training compliance for nursing staff in medicine at Royal Hampshire County Hospital. This data showed mandatory training compliance for nursing staff was close to, or above, the trust target for most mandatory training modules, including information governance.

Medical staff did not keep up-to-date with their mandatory training. Prior to our inspection, data received from the trust showed the trust target of 90% was not met for any mandatory training modules for which medical staff at Royal Hampshire County Hospital were eligible.

A breakdown of compliance for mandatory training courses from April to September 2019 for medical staff in medicine at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Conflict resolution	50	56	89.3%	90%	No
Moving and handling	49	56	87.5%	90%	No
Basic life support	45	56	80.4%	90%	No
Immediate life support	45	56	80.4%	90%	No
Equality and diversity	44	56	78.6%	90%	No
Health and safety (slips, trips and falls)	42	56	75%	90%	No
Infection control	37	56	66.1%	90%	No
Fire (1 year)	36	56	64.3%	90%	No
Information governance	35	56	62.5%	95%	No
Counter fraud	31	56	55.4%	90%	No
Dementia awareness (including privacy and dignity standards)	31	56	55.4%	90%	No
Medicine management training	5	56	8.9%	90%	No

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

During this inspection, we requested the most recent data (December 2019) for mandatory training compliance for medical staff at Royal Hampshire County Hospital. This data showed compliance for medical staff was improving. For example, completion rates for 'dementia awareness' and 'infection control' training had increased to 77% and 73%, respectively. However, medical staff still did not meet the trust target for any mandatory training modules.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they had enough time to complete mandatory training courses, and these courses were available through a variety of delivery methods including face-to-face and by use of the trust's own training platform, an application ('app') called 'Green Brain'. Staff told us this app improved remote access to mandatory training, and the trust reported increased rates of staff updating their key skills. Although the app had only been in place for a few months at the time of our inspection, staff we spoke with about mandatory training told us there was an improvement in the provision and completion of mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff were up to date with safeguarding training.

Safeguarding training completion rates

Staff had access to training specific for their role on how to recognise and report abuse and nursing staff kept up-to-date with safeguarding training.

During our last inspection, we reported that the service did not give safeguarding training enough priority as their target was only 80%. During this inspection, we found the trust target had increased to 90% and compliance with completion of safeguarding training had improved for nursing staff. However, medical staff completion rates for safeguarding training was still below trust targets.

A breakdown of compliance for safeguarding training courses from April to September 2019 for qualified nursing staff in medicine at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	190	206	92.2%	90%	Yes
Safeguarding children (level 1)	183	206	88.8%	90%	No

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

The trust's 90% target was met for one of the two training modules for which nursing staff in medicine at Royal Hampshire County Hospital were eligible.

During this inspection, we requested completion rates for safeguarding adults (level 2) and safeguarding children (levels 2 and 3). A breakdown of completion rates for these modules for nursing staff was as shown below:

- Safeguarding adult (level 2) – 74%
- Safeguarding children (level 2) – 86%
- Safeguarding children (level 3) – 73%

These figures were for December 2019 and were against a trust target of 90%.

A breakdown of compliance for safeguarding training courses from April to September 2019 for medical staff in medicine at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	27	56	48.2%	90%	No
Safeguarding children (level 1)	28	56	50%	90%	No

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

Medical staff did not always keep up to date with safeguarding training. The trust's 90% target was not met for either of the training modules for which medical staff in medicine at Royal Hampshire County Hospital were eligible.

During this inspection, we requested completion rates for safeguarding adults (level 2) and safeguarding children (levels 2 and 3). A breakdown of completion rates for these modules for medical staff was as shown below:

- Safeguarding adult (level 2) – 43%
- Safeguarding children (level 2) – 73%
- Safeguarding children (level 3) – 14%

These figures were for December 2019 and were against a trust target of 90%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with were able to explain how they would identify and report safeguarding concerns, and how they accessed support from the trust's safeguarding leads.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding concerns were entered on the electronic reporting system which went to the trust internal safeguarding leads. We were told "...staff are really good at raising concerns, receiving feedback and learning from safeguarding alerts".

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

During the last inspection, we observed examples of inconsistent infection control practices. For example, staff did not always use personal protective equipment (PPE) or adhere to the policy on being bare below the elbows. We also found a layer of thick dust on a resuscitation trolley, as well as inconsistent completion of hand hygiene audits.

On this inspection, all ward areas we visited were visibly clean with suitable and well-maintained furnishings. There were also arrangements for deep cleaning. We reviewed weekly cleaning audits for the period of November 2019 to January 2020 and saw the average cleaning score was between 95% and 100%.

Cleaning records were up-to-date and showed all areas were cleaned regularly. We reviewed some examples of cleaning checklists which confirmed areas were cleaned regularly.

Staff followed infection control principles, including the use of PPE. We observed staff using correct PPE, such as gloves and aprons, and were bare below the elbows in clinical areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers after cleaning equipment to show it was clean and ready to be used again.

The trust's infection prevention and control team, and wider governance structure, ensured oversight of practice and reporting of compliance. This ensured compliance with National Institute for Health and Care Excellence (NICE) [QS61] Infection prevention and control. Compliance with infection control policies was audited monthly and presented to the infection prevention committee.

The infection prevention and control team delivered training to clinical and non-clinical staff. We observed the infection prevention and control team provide advice on infection control practices for patients at risk of infection and those at risk around them during a board round.

Observational hand hygiene audits were undertaken monthly and results were displayed in ward areas. We saw results were close to or met the trust targets. During our inspection, we also observed staff washing their hands before and after patient contact.

National guidelines were followed for the screening of patients admitted to the medicine division. High-risk patients were screened for Methicillin-resistant *Staphylococcus aureus* MRSA in line with relevant criteria. All hospital-acquired infections, for example, MRSA, were investigated to look for key themes. This was monitored by the trust.

During our last inspection, we found patients with infections were nursed in open bays with limited infection control precautions. On this inspection, we found the trust was better at managing their use of beds in open days. The trust monitored infection control incidents and they had not seen any harm caused to patients who were cared for in these beds.

All wards we visited had working hand sanitiser dispensers and handwashing sinks located in clinical areas.

The Royal Hampshire County Hospital scored 99.7% for cleanliness and 98.2% for condition, appearance and maintenance of the environment in the 2019 patient-led assessment of the care environment (PLACE).

Environment and equipment

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

During our last inspection, we found equipment was not always necessarily safe and ready to use and checks on emergency equipment were not always completed. Following our last inspection, the endoscopy service lost its accreditation by the Joint Advisory Group (JAG) due to some environmental issues as well as a failure to meet mixed-sex facilities criteria.

During this inspection, we found the service had made improvements in these areas. The endoscopy service had addressed environmental issues and now had separate facilities for males and females with no crossover during pre-procedure and recovery. Staff told us that following the last inspection the department lost their JAG accreditation, they had followed the

recommendations in the trust action plan and had reobtained JAG reaccreditation. We found the environment in the endoscopy service to be clean and daily checklists were completed.

Patients could reach call bells and staff responded when called. At our last inspection, we told the trust they must provide appropriate equipment for patients in areas of escalation. During this inspection, we saw patients were provided with appropriate equipment when in escalation areas, including, for example, access to a call bell.

The design of the environment followed national guidance. There was appropriate room for patients to be cared for safely, and fire exits were clearly marked, with none of the exits blocked. Patients who required enhanced care were bedded in bays, with additional side rooms available.

The service had enough suitable equipment to help them to care for patients safely. We saw all equipment was serviced within the past 12 months to ensure it was safe for use. Staff had access to the equipment to help manage risk, for example, pressure-relieving and fall prevention equipment.

Staff disposed of clinical waste safely. We observed disposal and storage of clinical waste in line with current guidelines.

The service could not assure itself that resuscitation trolleys were always tamper-evident. For example, on Victoria ward, we found staff did not seal the resuscitation trolleys correctly which meant staff could not be assured equipment in the trolley would be available in an emergency. On all other wards we visited, tamper-evident seals were correctly sited and daily checklists completed.

Assessing and responding to patient risk

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

During our last inspection, we found staff did not always assess, monitor or manage risks, and we did not find assurances that the national early warning system (NEWS) was always used to correctly identify and escalate deteriorating patients appropriately. The World Health Organisation's (WHO) checklist was not completed in endoscopy at all times.

During this inspection, we found evidence of improvements.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary information to keep patients safe. Safety briefings were held to ensure important information was shared between staff. Board rounds appropriately discussed each patient to identify any risk areas, interventions required or those who were stable to step down from enhanced areas.

Staff completed risk assessments for each patient on admission/arrival and updated them when necessary and used recognised tools. We saw risk assessments recorded within patient records. Patients who were more acutely unwell or assessed as higher risk (for example for falls, pressure ulcers) would be bedded in the enhanced care bays rather than single rooms, which were staffed at all times. In addition, staff took other preventative measures such as repositioning the patient regularly if they were at risk of pressure damage.

The service had a restrictive practices policy, which was approved by the mental health committee. The policy included the use of rapid tranquillisation, observations required during and

after rapid tranquillisation, care planning and the reporting procedure of any episode of rapid tranquillisation.

Staff knew about and dealt with specific risk issues, including:

National Early Warning Score and Sepsis

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The national early warning score (NEWS 2) is a tool based on a scoring system reviewing six physiological measurements. A score is allocated and aggregated to determine a clinical response to acute illness. Staff could explain to us how they used this tool to identify a deteriorating patient, and who they would escalate any concerns to. The accurate completion and escalation responses using NEWS 2 was audited monthly, and trust wide compliance reported.

Staff received training on the recognition of sepsis and the need for early escalation, which was delivered alongside NEWS 2 training. A sepsis tool was used to screen patients and escalate. We saw evidence of appropriate escalation of patients suspected of having sepsis, and the sepsis screening tool completed.

The screening for sepsis was audited. Trust data, for the period of October to December 2019 for inpatient wards showed 93% of patients who met the criteria of the local protocol for sepsis screening were screened for sepsis using NEWS 2.

There were improvements in the number of patients who presented with severe sepsis and were administered intravenous antibiotic within one hour of diagnosis of sepsis. Audit results showed intravenous administration of antibiotics within one hour of diagnosis of sepsis rose from 83% in July 2019 to 90% in August 2019 and then 95% in September 2019.

Venous thromboembolism

All patients were risk assessed for venous thromboembolism (VTE) on admission to hospital and reassessed within 24 hours of admission or whenever the clinical situation changed. Trust data, for the period of October to December 2019, for hospital associated VTE, demonstrated 5 events within medical care for Hampshire Hospitals NHS Foundation Trust. This was an improvement from our last inspection where we found VTE risk assessments were not always carried out for patients in line with national guidance. Data provided by the trust demonstrated they were consistently below the national exemplar VTE rate for hospital associated thromboembolism and achieving CQUIN target of 95%.

We reviewed 14 patients' records, and all had a completed VTE risk assessment and medication was prescribed when necessary. We observed five completed electronic risk assessments.

Falls

Falls were being managed in the medical care service both for prevention and in response to a fall. We saw records to show staff had completed falls risk assessments. A 'hot debrief' led by the falls lead took place after every fall, allowing prompt review and investigation of the fall. For more serious falls, a root cause analysis was also completed.

Since our last inspection, the falls team (falls coordinator, clinical matron for frailty and falls, and a clinical lead for falls) had made improvements in the categorisation of falls to better understand moderate and severe falls. This demonstrated that falls with harm had reduced from approximately 150 in 2012/13 to just over 40 in 2018/19.

Pressure ulcers

The risk of a patient developing a pressure sore was not always assessed and actioned to reduce the risk. The trust had identified the number of reported grade two pressure ulcers had increased over time. We observed action plans and staff training to improve pressure ulcer care.

They had an action plan and shared learning for staff which included in house training by the tissue viability team, improved communication at handovers and weekly spot checks of the risk assessments.

Frail patients received care in the frailty unit, a 23-bed unit (three bays and three single bed rooms) alongside the acute medical unit and received an interdisciplinary complex geriatric assessment (CGA) on their first day of hospitalisation. The assessment was used to improve care planning, decrease length of stay in hospital and reduce readmissions. We reviewed examples of CGAs completed and found these to be detailed, with multidisciplinary involvement. If a patient arrived in hospital with a completed previous CGA this could be used and updated as required.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. The service was provided to inpatients Monday to Friday. Staff were also able to escalate concerns to the on-call mental health liaison team. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

During our last inspection, we reported that the endoscopy unit did not always complete the World Health Organisation (WHO) checklist and did not carry out WHO checklist audits. During this inspection, we found WHO checklists were consistently completed. The results of WHO checklist audits for 2019 showed compliance of 83% in April 2019, 88% in May, June and July 2019, 91% in August 2019, and 100% for all months up until and including January 2020.

Nurse staffing

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

The service acknowledged staffing continued to cause concern. The quarter two quality report for the quality and performance committee showed there were 155 registered nurse vacancies and 55 healthcare assistant vacancies across the service in September 2019. There was a reliance on agency and bank staff to provide safe staffing.

There remained a high qualified nursing vacancy rate of 27% against a target of 8% across the service between October 2018 to September 2019. However, only 4% of bank and agency hours remained unfilled (see table below).

Three new risks were added to the medicine division risk register in 2019. Following mitigations, these risks were reduced from a red to an amber rating.

Despite a high vacancy rates among nursing staff, the service was taking steps to effectively manage nursing staff.

All wards told us although there were concerns about staffing levels, the service had recently held a successful overseas recruitment event and had recruited new staff.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service used bank staff and, if this was not possible the same agency staff, where possible, to provide continuity.

Royal Hampshire County Hospital

The table below shows a summary of the nursing staffing metrics in medicine at Royal Hampshire County Hospital compared to the trust's targets, where applicable:

	Medicine annual staffing metrics						
	October 2018 to September 2019						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	505	19%	15%	3.5%			
Qualified nurses	196	27%	13%	3.2%	41,788 (11%)	29,456 (8%)	14,599 (4%)

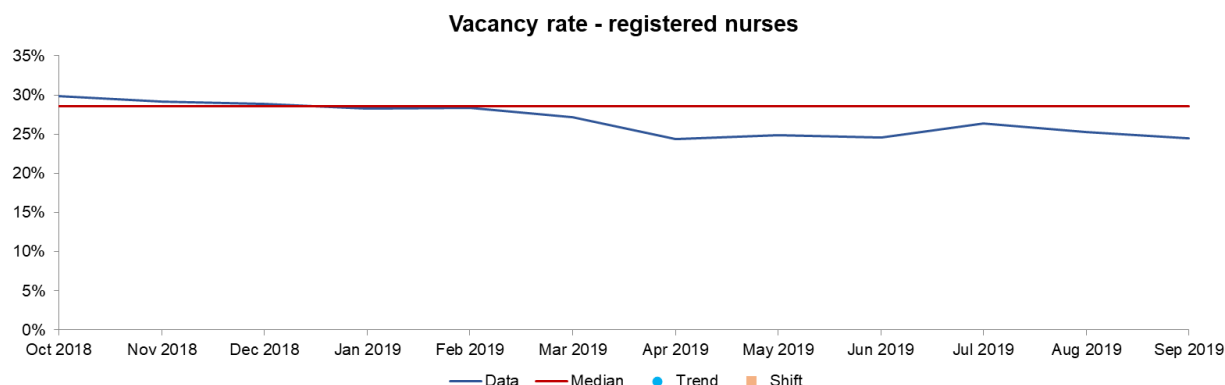
The ward manager could adjust staffing levels daily according to the needs of patients.

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

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

Vacancy rates

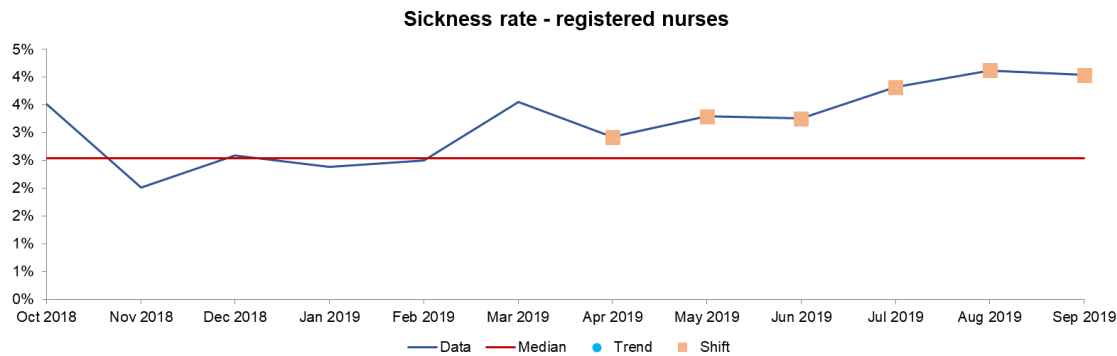
The service had a reducing vacancy rate for nursing staff. However, vacancy rates were still high.



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

Sickness rates

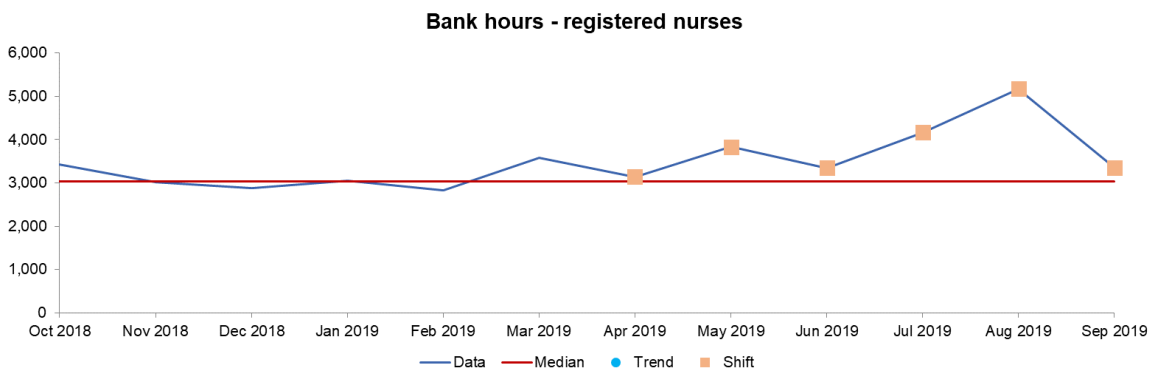
The service had an increasing sickness rates for nursing staff.



Monthly sickness rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019.

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

Bank staff usage



Monthly bank use over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019.

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

Medical staffing

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

Medical staffing and junior doctor staffing had increased since our last inspection, particularly in out of hours staffing. The service achieved this by advertising additional shifts and continuing with international recruitment campaigns. However, there was a high vacancy rate of 31% against a target of 8% across the service. This contrasts with the last inspection where we found medical staffing was over established by 12.9% at Royal Hampshire County Hospital between March 2017 and February 2018.

Senior staff told us there were consultant shortages in respiratory medicine which was causing a challenge in terms of progressing with plans for an ambulatory respiratory service.

Medical staff told us they were encouraged to progress in their career and junior doctors felt supported.

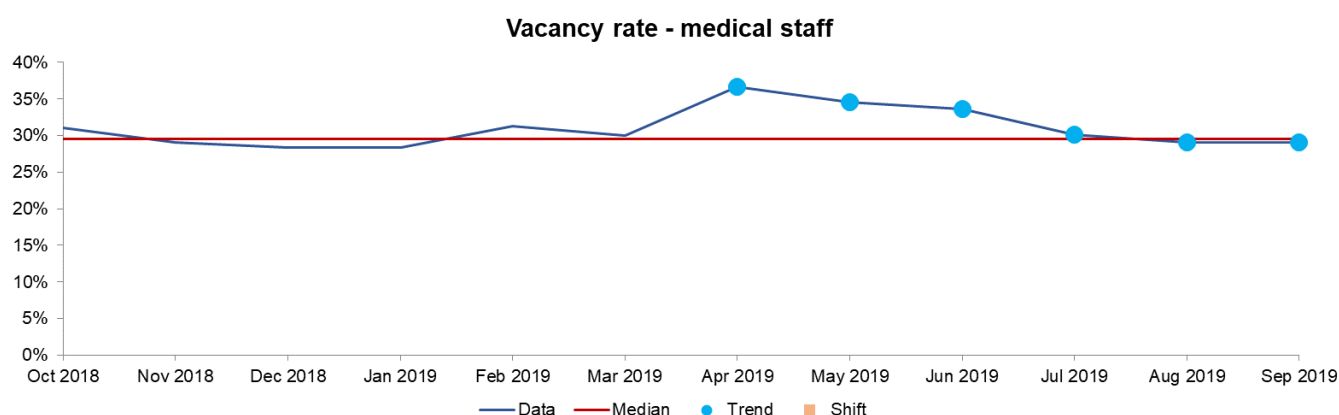
The table below shows a summary of the medical staffing metrics in medicine at Royal Hampshire County Hospital compared to the trust's targets, where applicable:

	Medicine annual staffing metrics						
	October 2018 to September 2019						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual locum hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	505	19%	15%	3.5%			
Medical staff	52	31%	22%	1%	0 (0%)	0 (0%)	0 (0%)

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

Vacancy rates

The service had reducing vacancy rates for medical staff. Monthly vacancy rates for medical staff showed a downward trend from April to September 2019.



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

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

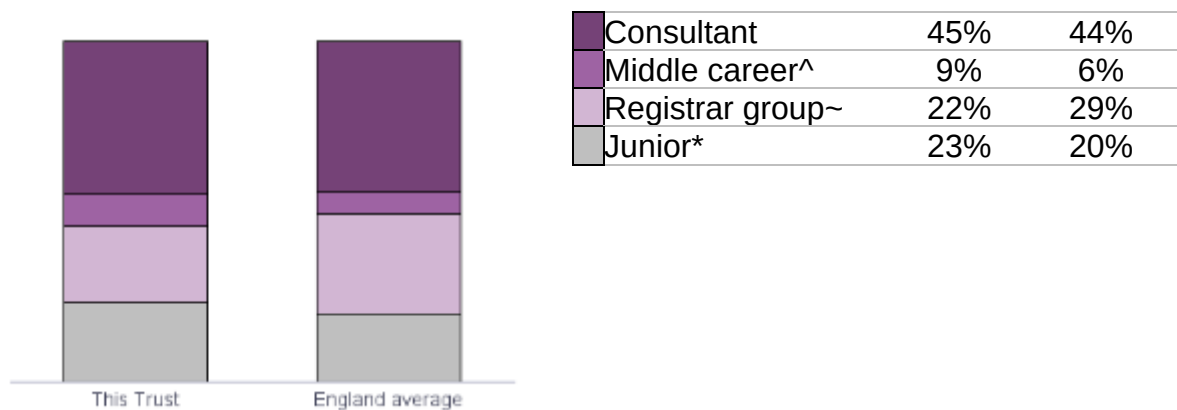
Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

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

Staffing skill mix for the 182 whole time equivalent staff working in medicine at Hampshire Hospitals NHS Foundation Trust

This Trust	England average



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

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

* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/08/2019 - 31/08/2019))

The service always had a consultant on-call during evenings and weekends.

Records

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

The trust used both paper and electronic records. Records were stored securely, and computers were logged off when not in use.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 14 patient records. The review of medical records demonstrated regular documenting of patient reviews undertaken by medical consultants, junior doctors and specialists.

When patients transferred to a new ward, there were no delays in staff accessing their records. Medical and nursing records were transferred with the patient.

Medicines

The service did not always use systems and processes to store and manage medicines safely. There were safe processes for the prescribing and administration of medicines.

During our last inspection, we reported the service did not have effective processes to manage medicines safely, and staff did not always follow best practice when storing, administering and disposing of medication

During this inspection, we still found the processes for the safe management of medicines did not always ensure medicines were managed safely, and staff did not always follow best practice when storing medicines. Although, processes for prescribing and administering medicines had improved.

Staff did not always store and manage medicines in line with the trust's policy. During this inspection, we found the process for storing out of date solutions had not improved. On Freshfield ward, there were out of date eye drops for a patient who had been discharged. On Clifton ward, liquids were not dated when opened to ensure use within an appropriate time frame. On Victoria ward, we found two boxes of out of date medicines dated March and August 2019.

On Victoria ward, we also found oxygen cylinders were not stored securely. Furthermore, three out of seven cylinders were empty, and a further two cylinders were half empty. Staff were not following safe storage and replenishment processes in line with trust policy.

During the previous inspection, we reported staff did not always check medicine fridge temperatures. This meant medicines were not always stored at the correct temperature in line with trust policy. During this inspection, we found this had not improved. On Victoria ward, daily fridge temperatures were consistently recorded at 17 and zero degrees. On discussion, we found staff did not always understand the significance of the recording and resetting processes.

On Wykeham ward, fridge temperatures were recorded. However, actions were not recorded when the temperature was outside of the agreed range. For example, we observed temperatures for the 5 and 12 of January 2020 were 17.8 and 11.8 degrees, yet no actions were recorded.

However, staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw special administration instructions for patients with particular medicines requirements. For example, we saw instructions to alert staff not to administer medicines if the patient's pulse was below an agreed level.

Staff followed current national practice to check patients had the correct medicines. There was a covert medication policy available to staff.

Staff completed monthly medication checks and monthly intravenous checks. These checks monitored whether patients received the correct medicine at the correct time. We saw results were close to or met the trust targets.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff spoken with were clear on the processes they followed to report incidents. They were able to talk to us about the learning which had been shared following incidents on their wards, or within the service. We saw evidence of incident outcomes on wards for staff to follow and learning needed from these. For example, a patient's care package had not been re-started when they were discharged, resulting in the patient being re-admitted. We were told this incident had resulted in increased communication internally and externally.

Managers shared learning about never events with their staff and across the service. This was shared through safety huddles, team meetings, newsletters and briefings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, we were told of an incident resulting in a patient experiencing a deep tissue injury, and the sharing of the outcome of the investigation with the patient's family. There was further shared learning from the incident with staff members across the service.

Never Events

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

From December 2018 to November 2019, the trust reported one never event for medicine:

A surgical/invasive procedure incident meeting Serious Incident criterion was reported at Royal Hampshire County Hospital in July 2019. The incident involved a gastroscopy undertaken on the wrong patient.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Royal Hampshire County Hospital

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, Royal Hampshire County Hospital reported nine serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2018 to November 2019. A breakdown of incidents by incident type is below:

Incident type	Number of incidents	Percentage of total
Pressure ulcer meeting SI criteria	3	33.3%
Slips/trips/falls meeting SI criteria	4	44.4%
Surgical/invasive procedure incident meeting SI criteria	1	11.1%
Treatment delay meeting SI criteria	1	11.1%
Total	9	100%

(Source: Strategic Executive Information System (STEIS))

The service had an improving culture of safety. The quarter two quality report for quality and performance committee outlined the increased completion of serious incident investigations, which resulted in identifying additional learning opportunities and change in practice. The report highlighted serious incident themes, for example, falls and pressure ulcers. As a result, there were two newly formed improvement groups led by the falls coordinator and tissue viability nurse.

There was evidence to show changes had been made as a result of feedback. We discussed with staff the pressure ulcers and falls incidents which met the serious incident criteria. Staff spoke about the learning shared from these incidents. For example, falls risk assessments and education had improved, with a 'hot debrief' after each fall. We saw these linked with the risks identified for the wards and division.

Safety thermometer

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

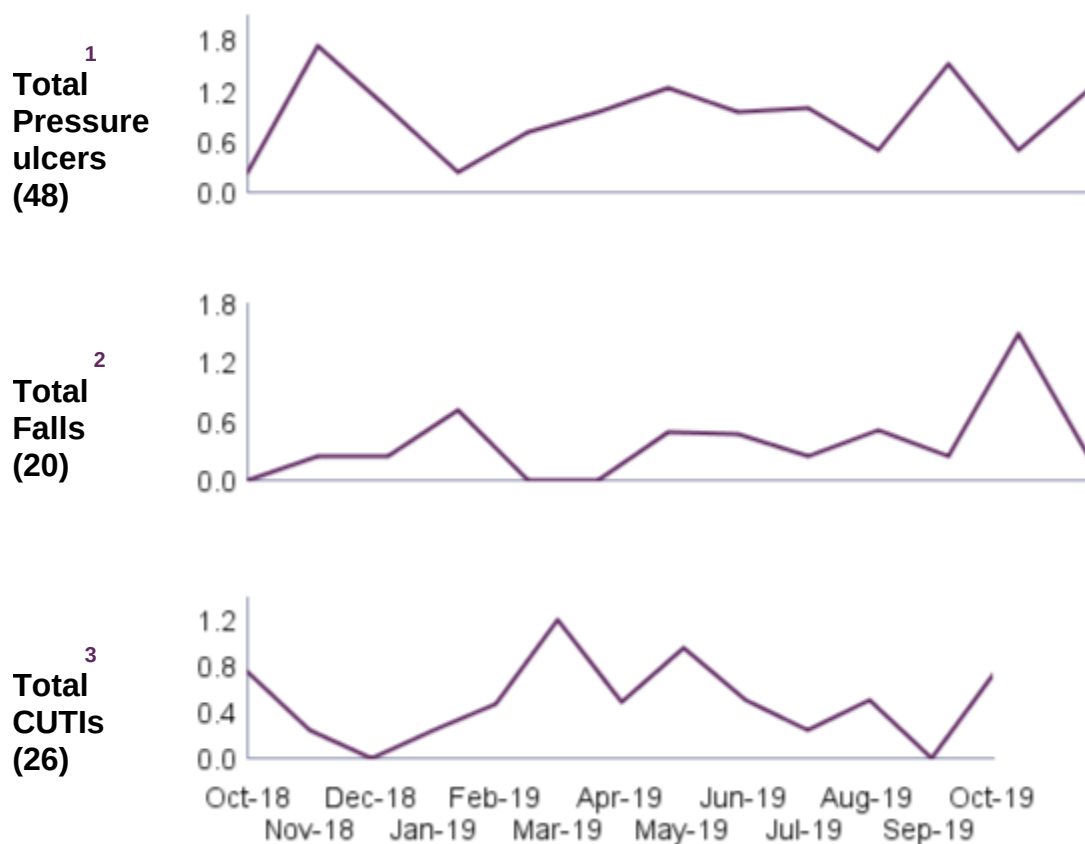
Safety thermometer data was displayed on wards for staff and patients to see. This information clearly displayed areas of safety that had improved and deteriorated.

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

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

Data from the Patient Safety Thermometer showed the trust reported 48 new pressure ulcers, 20 falls with harm and 26 new urinary tract infections in patients with a catheter from October 2018 to October 2019 for medical services. This showed an improvement in the number of falls with harm and new urinary tract infections but a deterioration in the number of pressure ulcers compared to data (for April 2017 to April 2018) from the Patient Safety Thermometer reported at the last inspection. This data showed the trust reported 45 new pressure ulcers, 28 falls with harm and 29 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.

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



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to local policies based on national guidance and links to National Institute of Clinical Excellence (NICE) guidance.

Twyford ward, which cared for stroke patients, had a target of admitting patients within four hours of arriving in hospital. This was in accordance with guidance from NICE [QS1] Prompt admission to specialist acute stroke units. This four-hour target was based on evidence that the stroke patients' outcomes were improved when they had quicker access to specialist care and treatment. The service had appointed a stroke care coordinator who supported teams across the service to ensure stroke patients were assessed and arrived on the ward as soon as possible so their treatment could be started at the earliest opportunity.

Staff on the ward had also stopped the practise of routinely catheterising patients because evidence showed this increased the risk of patients contracting urinary tract infections or losing bladder control. Where patients were catheterised, this was closely monitored, and the catheter removed as soon as it was no longer medically necessary. This was in line with NICE [QS4] Urinary catheters.

There were programmes of clinical audit to review compliance with standards. There was a multi-thronged approach to ensuring standards relevant to each speciality were being followed. The trust's clinical effectiveness team monitored the implementation of national guidance and challenged teams and departments on their performance if necessary.

The monthly medicine divisional board meeting minutes showed compliance with national guidance and evidence-based practice was monitored and challenged within the medicine division. The different specialities presented their performance to the medicines divisional board.

A report was also presented by the corporate governance team every six months to the trust's quality and performance committee on compliance with national guidelines. We reviewed the report presented in September 2019 which demonstrated effective compliance for the medicine division.

There was acknowledgement amongst service leaders of the need to formalise the process to reviewing policies to ensure care and treatment was based on national guidance and evidence-based practice. We were told, at the time of our inspection, a policy was being drafted.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We also saw this discussion happened at board rounds we attended.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it. We saw evidence of speech and language therapist involvement in the assessment and management of patients with swallowing difficulties or at risk of choking.

The wards we visited had protected meal times. This freed up staff to help patients eat and drink, and offered patients the opportunity to eat and drink with fewer distractions.

The service had adopted the International Dysphagia Diet Standardisation Initiative (IDDSI) framework. This framework aimed to remove the use of imprecise terms such as 'soft diet' and introduce standard terminology to describe texture modification for food and drink. We found effective implementation of this framework, with awareness of it among staff we spoke with. Staff were trained in the use of thickeners to thicken foods and fluids to various consistencies to ensure it was suitable for patients' individual needs.

Care plans we reviewed used the standardised terminology to identify the texture of food patients required, as well as identifying the level of support patients required during meal times. Patients requiring support during meal times were also identified during handovers, on their food charts and, with their permission, on white boards above their beds. The service also used the 'red tray' system to identify people who needed assistance to eat.

We reviewed the records of a patient who was receiving nutrition and fluids through a feeding tube directly into their stomach. The records showed the patients' feed ran on time and the tubes were flushed regularly to avoid blockages.

Staff were aware of patients who had to restrict their fluids and monitored fluid balance during comfort rounds.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Records we reviewed were completed as required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Records we reviewed were complete and scores were calculated correctly which helped to identify patient at risk of malnutrition. We also saw care plans to manage those at risk of malnutrition. For example, one care plan included close monitoring of the patient's weight and the involvement of a dietician and a speech and language therapist in their care.

Staff were knowledgeable about catering for patients of different cultural, religious or philosophical backgrounds.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a numerical score to measure pain experience by patients. An observational tool was used to measure pain in patients who had difficulties communicating, including those living with dementia.

Nurses checked and recorded patients' pain levels during routine observations, with patients asked about their pain level at least daily. Pain assessments were recorded on patients' national early warning score (NEWS) charts.

Patients received pain relief soon after requesting it. Patients we asked told us their pain was well controlled, including at night.

Staff prescribed, administered and recorded pain relief accurately. We saw evidence of this when reviewing prescription records.

A pain management team worked across the trust and were able to support patients admitted to hospital with pain review and management if necessary. Staff also involved the palliative care team in the management of pain where required. Anticipatory medicines were prescribed as appropriate to ensure patients received prompt relief from pain and other symptoms if their condition deteriorated.

We found staff did not use a body map to record the location of where transdermal patches used to administer pain relief were placed on patients. Transdermal patches are medicated adhesive patches placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream. This meant there was an increased chance of patches being placed in the same area of a patient's body, increasing the chance of causing irritability to a patient's skin. Staff also did not routinely check whether patches remained attached or record the date and time of when a patch was removed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Relative risk of readmission

Trust level

From June 2018 to May 2019, patients at the trust had a similar to expected risk of readmission for both elective (i.e. planned) and non-elective admissions when compared to the England average.

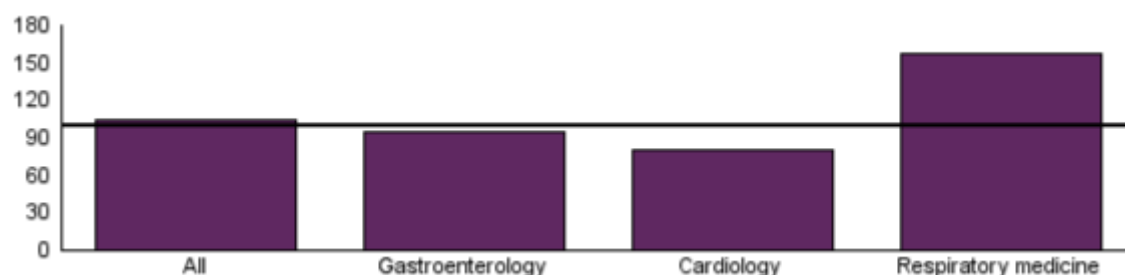
Elective admissions

- Patients in gastroenterology and cardiology had a lower than expected risk of readmission for elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for elective admissions

Non-elective admissions

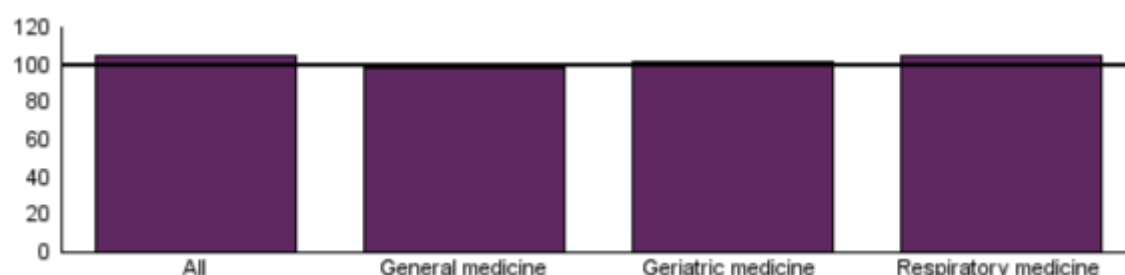
- Patients in general medicine and geriatric medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

Elective Admissions – Trust Level



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

Non-Elective Admissions – Trust Level



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

(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2018 - 31/05/2019))

Royal Hampshire County Hospital

From June 2018 to May 2019, patients at Royal Hampshire County Hospital had a higher than expected risk of readmission for elective (i.e. planned) admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

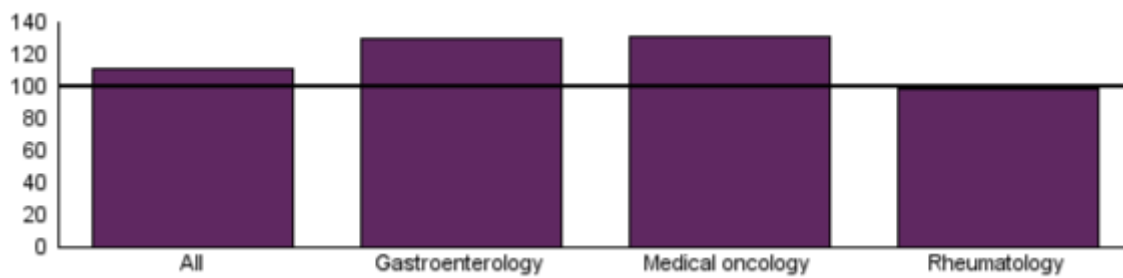
Elective admissions

- Patients in rheumatology had a lower than expected risk of readmission for elective admissions
- Patients in gastroenterology and medical oncology had a higher than expected risk of readmission for elective admissions

Non-elective admissions

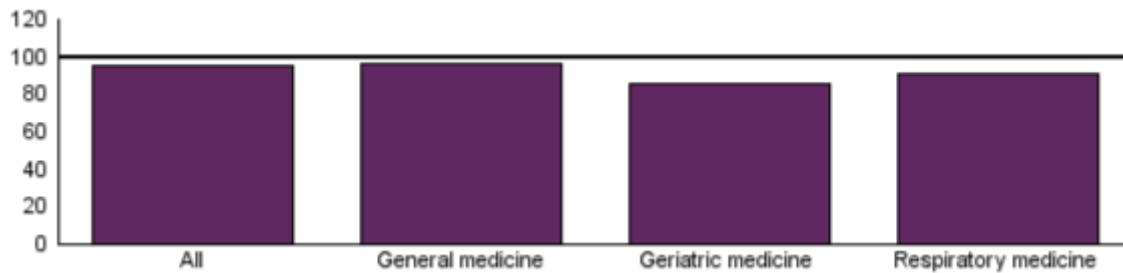
- Patients in general medicine and respiratory medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions

Elective Admissions - Royal Hampshire County Hospital



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

Non-Elective Admissions - Royal Hampshire County Hospital



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

Senior leaders explained there were operational pressures on staff to discharge patients as efficiently as possible, as soon as it was safe to do so. They explained this may mean some patients are discharged from hospital quicker than may have been the case historically, which may explain why at a trust-level and at Royal Hampshire County Hospital-level patients' chances of readmission were higher for some patients.

The trust had a programme to introduce ambulatory services for respiratory medicine and gastroenterology patients at the trust's two main sites (Basingstoke and North Hampshire Hospital, and Royal Hampshire County Hospital). These ambulatory services would offer patients the ability to undergo tests and treatments without having to be admitted to hospital. Senior leaders explained that, in addition to reducing the need for patients to be admitted to hospital in the first place, these services may also reduce the risk of readmissions for these patients.

Staff told us ambulatory services for gastroenterology patients had been trialled at Basingstoke and North Hampshire Hospital, and there were plans for it to be rolled out at Royal Hampshire County Hospital.

Space constraints at Royal Hampshire County Hospital, as well as a trust-wide issue of shortages in consultants in respiratory medicine, were sighted by senior leaders as challenges in progressing with plans for an ambulatory service for respiratory medicine patients.

The service participated in relevant national clinical audits. The outcomes for patients were variable and did not always meet expectations, such as national standards.

Managers and staff used audit results to improve patient outcomes. This included an action plan to improve the service's performance in the Sentinel Stroke National Audit Programme.

Managers shared and made sure staff understood information from the audits. Results from audits were presented and learning shared at service-specific meetings, divisional performance review meetings and divisional governance meetings. For example, the results from the Sentinel Stroke

National Audit Programme were discussed at fortnightly stroke strategy meetings as well as weekly stroke education meetings which all staff were invited to attend.

The service was accredited by the Joint Advisory Group (JAG). At the time of our last inspection, the endoscopy service at Royal Hampshire County Hospital was no longer accredited by JAG. On this inspection, following improvements that had been made, JAG accreditation had been reobtained on all sites including Royal Hampshire County Hospital.

Sentinel Stroke National Audit Programme (SSNAP)

Royal Hampshire County Hospital

Royal Hampshire County Hospital took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, April to June 2019.

In comparison the previous time period, January to March 2019, for April to June 2019, performance in the scanning and stroke unit domains was upgraded from a level C to a level B and thrombolysis was upgraded from a level D to a level C, for both patient and team centred performance. However, speech and language therapy was downgraded from a level C to a level E, for both patient and team centred performance (see tables below).

<u>Patient centred performance</u>	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19
Domain 1: Scanning	B↑	C↓	B↑	C↓	B↑
Domain 2: Stroke unit	C	C	C	C	B↑
Domain 3: Thrombolysis	C	D↓	C↑	D↓	C↑
Domain 4: Specialist assessments	B	B	B	B	B
Domain 5: Occupational therapy	B↓	B	A↑	A	A
Domain 6: Physiotherapy	B↓	A↑	A	A	A
Domain 7: Speech and language therapy	C↓	B↑	D↓↓	C↑	E↓↓
Domain 8: Multi-disciplinary team working	C	D↓	C↑	D↓	C↑
Domain 9: Standards by discharge	B	B	B	B	B
Domain 10: Discharge processes	A	B↓	C↓	B↑	B
Patient-centred total key indicator level	B	B	B	B	B

<u>Team centred performance</u>	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19
Domain 1: Scanning	B↑	C↓	B↑	C↓	B↑
Domain 2: Stroke unit	C	C	C	C	B↑
Domain 3: Thrombolysis	C	D↓	D	D	C↑
Domain 4: Specialist assessments	B	C↓	B↑	B	B
Domain 5: Occupational therapy	B↓	B	A↑	A	A
Domain 6: Physiotherapy	B↓	A↑	A	A	A
Domain 7: Speech and language therapy	C	B↑	C↓	C	E↓↓
Domain 8: Multi-disciplinary team working	C	D↓	C↑	D↓	D
Domain 9: Standards by discharge	B	B	B	B	B
Domain 10: Discharge processes	A	B↓	C↓	B↑	B
Team-centred total key indicator level	B	C↓	B↑	B	B

Overall Scores	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19
SSNAP level	B	C↓	B↑	B	B
Case ascertainment band	A	A	A	A	A
Audit compliance band	A	A	A	A	A
Combined total key indicator level	B	C↓	B↑	B	B

Best **A** **B** **C** **D** **E** Worst **N/A** No assessment

Source: Royal College of Physicians London, SSNAP audit)

Senior leaders told the reason for the downgrading of speech and language therapy was due to staff shortages due to staff going on parental leave. They explained they had taken action to increase capacity in the short term but also ensure greater resilience in workforce capacity for the future.

National Diabetes Inpatient Audit; Myocardial Ischaemia National Audit Project (MINAP)

The trust was continuing to participate in the National Diabetes Inpatient Audit, MINAP and Heart Failure Audit. We asked the trust for the most recently published results from these audits. At the time of writing this report, the trust had only provided one of these audit results.

Heart Failure Audit

The table below summaries Royal Hampshire County Hospital's performance in the 2019 Heart Failure Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Met national standard?
Case ascertainment	91%	Better than national aggregate	N/A
Crude proportion of inpatients admitted with Heart Failure (HF) who receive input from the specialist team	77.4%	Worse than national aggregate	Did not meet
Crude proportion of inpatients admitted with HF who receive cardiology follow up	43.1%	Worse than national aggregate	Did not meet
Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: an ACEI/ARB	80.6%	Worse than national aggregate	Did not meet
Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: Beta-blocker	85.7%	Worse than national aggregate	Did not meet
Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: Mineralocorticoid receptor antagonist (MRA)	62.1%	Better than national aggregate	Did not meet

The hospital performed worse in comparison to other trusts for four of six metrics in this audit. The hospital also failure to meet the national standards in all metrics for which there was a national standard.

We asked the trust for their action plans to improve performance in these audits. At the time of writing this report, the trust had not provided us with this information.

Lung Cancer Audit

The table below summarises Hampshire Hospitals NHS Foundation Trust's performance in the 2018 National Lung Cancer Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Met national standard?
Crude proportion of patients seen by a cancer nurse specialist <i>(Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</i>	68.1%	Does not meet the audit aspirational standard	Did not meet
Case-mix adjusted one-year survival rate <i>(Adjusted scores take into account the differences in the case-mix of patients treated)</i>	34.3%	Within expected range	No current standard
Case-mix adjusted percentage of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery <i>(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)</i>	18%	Within expected range	Met
Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment <i>(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</i>	63.5%	Within expected range	Did not meet
Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy <i>(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</i>	64.1%	Within expected range	Did not meet

(Source: National Lung Cancer Audit)

The trust's performance was 'within the expected range' for four of the five indicators in the lung cancer audit. However, the trust did not meet the audit aspirational standard for the metric concerning the proportion of patients seen by a cancer specialist. The trust did not meet the national standard for three of the four metrics for which there was a current standard.

We asked the trust for its action plan to improve its performance in this audit. At the time of writing this report, the trust had not provided us with this information.

National Audit of Inpatient Falls

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the 2017 National Audit of Inpatient Falls.

As above, the audit reports on the extent to which key indicators were met and grades performance as follows:

- red (less than 50% of patients received the assessment/intervention)
- amber (between 50% and 79% of patients received the assessment/intervention)
- green (more than 80% of patients received the assessment/intervention).

Metrics (Audit measures)	Hospital performance	Audit's Rating	Met national aspirational standard?
Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?	Yes	N/A	Met
Crude proportion of patients who had a vision assessment (if applicable) <i>(Having a vision assessment is indicative of good practice in falls prevention)</i>	84.2%	Green	Did not meet
Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) <i>(Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</i>	37.5%	Red	Did not meet
Crude proportion of patients assessed for the presence or absence of delirium (if applicable) <i>(Having an assessment for delirium is indicative of good practice in falls prevention)</i>	15.8%	Red	Did not meet
Crude proportion of patients with a call bell in reach (if applicable) <i>(Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</i>	66.7%	Amber	Did not meet

(Source: National Audit of Inpatient Falls)

Royal Hampshire County Hospital was 'red' or 'amber' rated against most of the metrics in the audit. The hospital also failed to meet the national aspirational standards for four of the five reported metrics.

We asked the trust for its action plan to improve its performance in this audit. At the time of writing this report, the trust had not provided us with this information.

Chronic Obstructive Pulmonary Disease Audit

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the October 2018 to April 2019 Chronic Obstructive Pulmonary Disease Audit.

Metrics (Audit measures)	Hospital performance	Audit's Rating	Met national standard?
Percentage of patients seen by a member of the respiratory team within 24hrs of admission? <i>(Specialist input improves processes and outcomes for COPD patients)</i>	72.8%	Better than the national aggregate	Met
Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) <i>(Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)</i>	98.3%	Worse than the national aggregate	Did not meet
Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival <i>(NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</i>	38.9%	Better than the national aggregate	Met
Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy <i>(Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</i>	60.5%	Better than the national aggregate	Did not meet
Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission <i>(Completion of a discharge bundle improves readmission rates and integration of care)</i>	91.4%	Better than the national aggregate	Met
Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file <i>(A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</i>	Data not available	N/A	N/A

(Source: Chronic Obstructive Pulmonary Disease Audit)

Royal Hampshire County Hospital performed 'better than the national aggregate' for most of the metrics and met the national standards for three of the six metrics in the October 2018 to April 2019 Chronic Obstructive Pulmonary Disease Audit. Royal Hampshire County Hospital performed 'worse than the national aggregate and failed to meet the national standard against one of the metrics in the audit: percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%).

The trust did not provide us with data for one of the metrics in the audit pertaining to Royal Hampshire County Hospital (specifically, the percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file).

We asked the trust for its action plan to improve its performance in this audit. At the time of writing this report, the trust had not provided us with this information.

National Audit of Dementia

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the 2018 National Audit of Dementia.

Metrics (Audit measures)	Hospital performance	Audit's Rating	Met national standard?
Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good <i>(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</i>	82.4%	Better	No current standard
Percentage of staff responding "always" or "most of the time" to the question "Is your ward/ service able to respond to the needs of people with dementia as they arise?" <i>(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</i>	74.4%	Similar	No current standard
Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium <i>(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</i>	68%	Similar	No current standard

Multi-disciplinary team involvement in discussion of discharge <i>(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</i>	94.7%	Better	No current standard

(Source: National Audit of Dementia)

Royal Hampshire County Hospital was rated 'better' or 'similar' against the four metrics in the 2018 National Audit of Dementia. Royal Hampshire County Hospital performed better in the audit compared to Basingstoke and North Hampshire Hospital, which was rated 'worse' in one of the metrics (specifically, mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium).

We asked the trust for its action plan to improve performance in this audit. At the time of writing this report, the trust had not provided us with this information.

Competent staff

The service sought to make sure staff were competent for their roles. However, not all staff groups achieved the trust's target for completion of yearly appraisals.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Competencies relevant to the ward specialty and staff role were completed by staff during their induction training and on an ongoing basis.

The trust provided staff in the hospital with simulation training where manikins were programmed to imitate real patients' illness, giving staff the opportunity to prepare for real-life clinical scenarios, including cardiac arrests or medicine-related incidents (for example medication overdoses). Staff spoke positively about this training, with one staff member saying it gave them "greater confidence".

Managers gave all new staff a full induction tailored to their role before they started work. New members of staff we spoke with told us the induction process prepared them for the role, and they received appropriate support from managers. New members of staff were not allowed to practice any procedures until they were deemed competent to do so, with senior nursing staff tasked with approving documentation of their competency. Comments from new members of staff we spoke with included the following: "I had a proper induction when I started. It made me feel confident doing my job competently", and "You are not pushed to do anything you don't feel comfortable doing."

Junior doctors we spoke with, who at the time of our inspection had recently started working at the trust, were positive about the induction process and ongoing consultant support.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. As at September 2019, 90.2% of staff in the medicine division at Royal Hampshire County Hospital received an appraisal compared to a trust target of 90% (see table below). This was an improvement compared to how the service was found to be performing at the last inspection

where 46.9% of staff in the medicine division at the hospital had received an appraisal between April 2017 to February 2018.

As at September 2019, most nursing and medical staff had received an appraisal, though neither staff group achieved to hit the trust target of 90%.

Staff we spoke with who had received an appraisal spoke positively about the process.

Royal Hampshire County Hospital

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Estates and ancillary	7	7	100%	90%	Yes
Additional clinical services	151	157	96.2%	90%	Yes
Administrative and clerical	58	62	93.5%	90%	Yes
Nursing	144	164	87.8%	90%	No
Medical	5	6	83.3%	90%	No
Allied health professionals	23	28	82.1%	90%	No
Total	388	424	91.5%	90%	Yes

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

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes from meetings were available for staff who were unable to attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with told us they had access to, and were encouraged to undertake, further training to develop their skills and knowledge. Most staff we spoke with were positive about access to training and development.

Managers made sure staff received any specialist training for their role. This included training for staff on Clarke ward to interpret electrocardiography (ECG) charts.

Managers identified poor staff performance promptly and supported staff to improve. Managers monitored poor performance through the appraisal process and through support from the human resources team.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We attended board rounds on different wards during our inspection where we observed multidisciplinary attendance and participation. For example, on Clarke ward, which specialised in the care of cardiology and stroke patients, we observed a multidisciplinary board round where staff from all professional backgrounds took the time to discuss each patient and were comfortable to speak up and challenge each other.

Staff worked across health care disciplines and with other agencies when required to care for patients. On Twyford and Clarke wards, which cared for stroke patients, staff from across health

care disciplines including physiotherapists, occupational therapists, and nursing and medical staff, worked together to deliver care and treatment to patients. A member of staff told us, "We work as a team. We are a good example of how multidisciplinary work should function."

On Twyford ward, a multidisciplinary team met daily to ensure patients were regularly assessed to identify patients that could be transferred to ensure a bed was always available on the ward for more acute stroke patients.

Patients could and were referred to services within the trust and externally to ensure a multidisciplinary approach to their care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke with were aware of the trust's mental health liaison team and knew how to make a referral to them if needed. Staff spoke positively about the support from the mental health liaison team.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients had their care pathway reviewed by relevant consultants.

Staff could call support from doctors and most other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The trust participated in mandatory audit of performance against the seven-day standards. The seven-day standards programme was designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Ten clinical standards for seven-day services in hospitals were developed in 2013, defining what seven-day services should achieve, no matter when or where patients are admitted. Four of the 10 clinical standards were identified as priorities because of their potential to positively affect patient outcomes.

Data provided by the trust following an audit in July 2019 showed the trust was compliant with the four priority standards:

- Standard 2: consultant review within 14 hours of decision to admit was met.
- Standard 5: access to diagnostic tests and reporting was met.
- Standard 6: access to consultant directed interventions was met at a trust level, though they were not always met at local level. The standard was met for cardiac pacing and percutaneous coronary intervention at the Basingstoke site only, and for stroke thrombolysis at the Winchester site only.
- Standard 8: ongoing daily consultant review for inpatients was met.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Information in leaflets and posters promoting healthier lifestyles including smoking cessation was present in many ward areas.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients had risk assessments undertaken as part of their admission. This information was available for nursing and medical staff to advise as appropriate on changes to lifestyle, including smoking cessation and weight loss. We observed staff give health promotion advice to patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff followed the trust policy and procedures when a patient could not give consent. We observed staff discuss where patients were unable to consent and found that staff were using correct documentation in these cases.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Consent forms we reviewed clearly recorded details of patient consent to care and treatment.

Mental Capacity Act and Deprivation of Liberty training completion

Staff did not always keep up-to-date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Royal Hampshire County Hospital for staff in medicine showed that 68.5% of medical staff and 67.3% of nursing staff were compliant. This was below the trust's compliance target of 90%.

Staff we spoke with who had completed the trust's e-learning training on mental capacity assessments spoke highly of the quality of this training.

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. In medicine, the target was not met for MCA/DoLS training modules for which nursing and medical staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at trust level for nursing staff in medicine is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	298	444	67.1%	90%	No

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at trust level for medical staff in medicine is shown below:

Training module name	April to September 2019

	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	104	182	57.1%	90%	No

Royal Hampshire County Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Royal Hampshire County Hospital for qualified nursing staff in medicine is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	132	196	67.3%	90%	No

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Royal Hampshire County Hospital for medical staff in medicine is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	37	54	68.5%	90%	No

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

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

The introduction of electronic patient records meant patients' journey in the service system was more accurately recorded and easily accessed by staff including nurses, allied health professionals and medical staff.

Is the service caring?

Compassionate care

Royal Hampshire County Hospital

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection, we observed positive interactions between staff and patients, providing kindness in care. We found the atmosphere on the wards was tranquil and calm, which was appropriate to meet the needs of the patient groups. We observed staff introduce themselves by name to patients and their families. Staff described their role and discussed, with the patient, their care and what would happen next.

We saw staff confirm if they understood everything and asked patients and, where appropriate, their families or carers, if they had any questions.

Patients said staff treated them well and with kindness. We found thank you cards on all the wards we visited from patients or their relatives, expressing their thanks for the care and treatment they received.

Staff encouraged and supported patients to get dressed during the day to maintain their dignity and privacy.

Patients we spoke with said staff responded to call bells in a timely manner, and staff would always stop and speak to them in spite of being very busy. On a ward, we saw an activity coordinator involving patients in a quiz, and patients giving positive feedback about the experience.

We received positive feedback directly from patients and family members:

“Excellent care...really supportive” – acute elderly care ward

“Always reassuring when I am frightened, and have time to talk to me” – acute medical unit

“Always ready to listen...” – hyper acute stroke unit

“...best ward I have ever been on” – acute elderly care ward

“The support given to us during his stay was amazing, and your care made what was a difficult time less stressful.” – inpatient cardiology and stroke ward

Staff were keen to make sure patients received great care and were responsive to concerns patients raised.

Staff followed policy to keep patient care and treatment confidential. Staff spoke quietly or within private areas when discussing patient care and treatment. Curtains were pulled around patients' beds during conversations regarding their care and treatment.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff talking to patients with mental health needs in a caring and inclusive way. We saw staff explaining treatment options to patients and family members and making decisions together.

Staff took time to interact with patients and those close to them in a respectful and considerate way. All patients and those close to them said staff treated them well and with kindness. They told us they felt heard and understood by staff. They felt like partners in their care.

We heard a patient singing and staff members joining in. Patients were greeted in a familiar way, and staff chatted to patients during times of personal care.

Staff felt patient care was exceptional and proactive. We were told staff love elderly care and view it as “a real speciality”.

The patient-led assessment of the care environment (PLACE) in 2019 scored Royal Hampshire County Hospital 82% for privacy, dignity and wellbeing. This was an improvement on the 2018 result of 72%.

Emotional support

Royal Hampshire County Hospital

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Everyone clearly understood the impact a person's care, treatment and condition had on their wellbeing and those close to them and responded to this accordingly. Discussions with staff demonstrated a strong commitment to ensuring they understood the entirety of a patient's situation and its impact.

The trust provided a multi-denominational pastoral care service. Staff knew how to access this service if required. The chaplaincy, when requested, provided services at the bedside.

The endoscopy service had access to private rooms for breaking news to patients. Staff were clear in how to inform a patient of test results, which would include the consultant and nurse specialist.

The dementia team provided emotional support to patients and families on the wards. The dementia team were informed when a patient living with dementia was admitted to the hospital, and they provided emotional support on discharge, escorting the patient back to a nursing care environment. They also provided support and gave advice on de-escalation, which included guiding hands and low-level holds.

The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form was used for personalised and compassionate end of life care. ReSPECT stickers were added to a patient's notes to ensure all staff were aware to provide sensitive and compassionate care. The palliative care team supported staff in caring for these patients.

Understanding and involvement of patients and those close to them

Royal Hampshire County Hospital

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

Staff made sure patients, and those close to them, understood their care and treatment. All inpatient wards we visited had adopted a campaign allowing carers of patients with dementia to stay in hospital with their loved ones if they wish.

We observed staff support the families and carers of patients, teaching them how to care for patients safely to prepare them to support patients at home when patients were eventually discharged.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to communication aids to help patients become partners in their care. We saw pictorial cards on wards and staff using these to assist patients.

Staff supported patients to make advanced decisions about their care. The palliative care team worked closely with the medical care services to provide support with difficult conversations for both patients and those close to them.

Patients and their families could give feedback on the service and their treatment, and staff supported them to do this.

Posters and leaflets were available in the wards we visited inviting patients and visitors to anonymously provide feedback on their experience through the Friends and Family Test. There were also communications to inform patients and visitors of how they could contact the trust's customer care team to feedback on the service and their treatment.

Staff supported patients to make informed decisions about their care. For example, we witnessed a member of staff explain the benefits and risks of treatment to a patient, so the patient could make an informed decision.

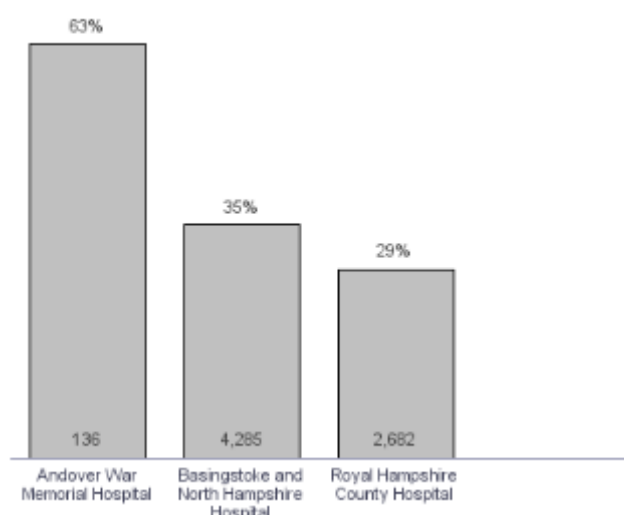
Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 33% which was better than the England average of 24% from October 2018 to September 2019.

As seen in the chart below, response rates between October 2018 to September 2019 varied by site, with Andover War Memorial Hospital achieving a response rate of 63% compared to Royal Hampshire County Hospital which achieved a response rate of 29%.

Senior leaders told us the relatively lower response rates at Royal Hampshire County Hospital was an issue they were aware of and that they were in discussions as to how to improve this. At the time of our inspection, the trust did not have an action plan for this.

Friends and family Test – Response rate between October 2018 to September 2019 by site



Ward name	Total Resp ^{1,2}	Resp. Rate	Percentage recommended ³												Annual perf ¹
			Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Oct-19	
MCGILL AMU IP	1,075	23%	90%	88%	92%	89%	93%	92%	90%	93%	96%	93%	95%	84%	91%
CCU IP	943	47%	97%	98%	98%	96%	98%	99%	99%	96%	100%	96%	96%	94%	97%
BAEC	755	29%	100%	99%	97%	98%	100%	100%	93%	97%	100%	99%	100%	98%	99%
AAU IP	630	24%	86%	87%	92%	86%	90%	85%	94%	86%	95%	97%	98%	95%	91%
E3 IP	383	42%	88%	93%	92%	100%	97%	90%	94%	97%	97%	97%	93%	88%	95%
FRESHFIELD IP	310	68%	100%	94%	94%	91%	97%	100%	91%	97%	96%	97%	88%	96%	95%
E1 IP	295	38%	96%	100%	90%	96%	94%	87%	100%	95%	100%	95%	100%	93%	96%
CLIFTON IP	274	50%	96%	100%	100%	95%	100%	100%	97%	96%	100%	100%	83%	100%	98%
VICTORIA IP	268	27%	86%	100%	86%	100%	84%	100%	98%	96%	95%	95%	94%	90%	94%
ST CROSS IP	260	34%	100%	98%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	99%
F1 IP	257	62%	100%	88%	80%	79%	100%	100%	96%	100%	95%	100%	100%	100%	96%
E4 IP	246	28%	100%	97%	92%	87%	96%	96%	100%	100%	100%	90%	100%	93%	96%
F3 IP	218	63%	100%	92%	100%	100%	95%	78%	97%	95%	96%	100%	92%	96%	95%
WAINWRIGHT IP	214	41%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	93%	100%	87%
CLARKE IP	212	28%	88%	86%	100%	97%	100%	100%	100%	96%	100%	100%	100%	100%	89%
EIW IP	208	65%	94%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	99%
WESSEX WX IP	150	39%	100%	91%	100%	100%	100%	100%	100%	100%	92%	100%	90%	100%	97%
KINGFISHER IP	147	68%	90%	100%	94%	100%	100%	75%	100%	100%		100%	95%	94%	95%
E2 IP	129	22%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	85%
F2 IP	104	46%				90%	100%	83%	88%	100%	85%	100%	80%	96%	87%

Key Highest score to lowest score
 100% 50% 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

Patients were admitted to the wards by direct referral from their GP, a critical care unit (step down care), the emergency department and the Same Day Emergency Care (SDEC) unit.

The service also considered how to work within the healthcare system to provide care and advice. Since our last inspection, the SDEC unit, which is located next to the hospital's emergency department, had opened. This unit enabled medical care patients to be seen and assessed promptly by clinicians and had helped reduce the likelihood of patients being admitted for an overnight hospital stay. The unit accepted referrals from GPs and the emergency department. There were current plans to incorporate a pathway for paramedics to directly refer patients to the unit. The unit was open Monday to Friday 8am to 6pm and Sunday 8am to 4pm. It was closed on Saturdays.

The McGill acute medical unit was also reconfigured since our last inspection, with one half allocated for frailty admissions and the other half for enhanced care. The frailty unit was opened two years ago to provide specialist care to older people in the community. Both the acute medical unit and frailty unit was open 24 hours a day, seven days a week. We were told both units were always busy and relieved pressures from the emergency department.

The service had a delayed transfer of care ward, Freshfield ward. Patients who were medically fit for discharge, but unable to be discharged from hospital due to complex circumstances or waiting for packages of care, were cared for on this ward. Patients without a discharge plan were not accepted to this ward.

Twyford ward provided hyper-acute stroke care and stroke rehabilitation. The ward also had an early supported discharge team. This helped patients to return home at an earlier point in their recovery, to continue with their rehabilitation with the support of the hospital stroke therapy team.

Facilities and premises were appropriate for the services being delivered. Wards were designed to care for sick or at-risk patients in the enhanced care bays, which had staff present at all times, with other patients using the side rooms. There were dementia friendly wards with areas to encourage interaction between patients and staff. We saw tables with newspapers and crosswords for staff and patients to sit together.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We reviewed mixed sex breaches data which demonstrated there had been no breaches for the period September 2018 to September 2019. Staff told us there were no mixed sex breaches between September 2019 and the period of inspection. This was an improvement following our last inspection.

The service had systems to help care for patients in need of additional support or specialist intervention. Referrals could be made to the dementia liaison team, learning disability and mental health teams and the social care team through the trust systems, email or telephone. There was rapid access to specialties.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. During our last inspection, we reported that the recording of personalised care planning and dementia care plans were not effectively completed. During this inspection, we saw improvements in personalising care planning. For example, on Clifton ward, we saw ReSPECT plans used in conjunction with ongoing capacity assessments and continuing healthcare discussions, with involvement from patients and family members.

ReSPECT plans were created through conversations between patients and the clinicians and included the priorities for care, agreed recommendations about care and treatment. This enabled the patient to achieve the outcome they desired. We saw regular entries for patients that appeared confused with updating of their personalised care plans.

On Twyford ward, we saw the *Achieving Priorities of Care* pathways for end of life patients. Documents were completed by patients, relatives and the palliative care team.

The trust had a learning disability team and the team helped review the best place for a patient to stay, for example, the privacy of a single room, a quiet space with less stimulation, or a shared space for patients with communicate difficulties.

The trust had a mental health liaison team which included consultants and nurses. They operated an inpatient service between 8.45am and 5pm Monday to Friday. They helped to support both patients and staff.

Wards were designed to meet the needs of patients living with dementia. The service had a dementia team to support staff to care for patients with dementia. Sunflowers were used to identify patients living with dementia. Dementia care was considered a priority within the service and there were dementia champions on the wards.

There were some adaptations to the environment designed to meet the needs of patients living with dementia. For example, in the frailty unit, there were colour coded areas and large symbols to display toilets and bathrooms.

We reviewed dementia care audit results between the period of October to December 2019, which consistently demonstrated patients had 'This Is Me' booklets completed within 48 hours of

admission, personalised care plans started, Abbey Pain Scale completed, and a sunflower symbol placed above the bed of patients living with dementia, on admission.

The patient-led assessment of the care environment (PLACE) in 2019 scored Royal Hampshire County Hospital 71.9% for whether the premises were equipped to meet the needs of people with dementia. This was an improvement on the 2018 result of 59.9%.

Falls training was ongoing and education for staff included face-to-face training during induction and every two years for an update. The falls team planned to produce an e-learning training module in the few months following our inspection and to deliver a new post-falls training session.

We were told the falls team had delivered information on falls to staff through a falls conference, focus on falls, falls update newsletters and falls friend talks. This had raised awareness among staff of falls risks. Since the last inspection, the falls policy was updated to align with the national audit of inpatient falls.

The service had activity coordinators and activities were run on the wards. We observed a quiz delivered by the activity coordinator on a ward, and posters on wards informed patients of available activities, including times and locations.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us how they could access telephone-based interpretation services. The service and the wider hospital also had a multilingual work force which was sometimes used to translate information to patients while a translator was being arranged.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed lunch time on one ward. All staff helped to bring patients their food. There were several choices available, and the housekeepers said they could order sandwiches if there was an admission after lunch or patients were hungry. Special diets were catered for. Hot drinks were offered at set times during the day, but staff told us they would make patients a hot drink if requested.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Staff we spoke with told us of improvement with flow (i.e. managing patients effectively with minimal delays) across the hospital with the introduction of the Same Day Emergency Care (SDEC) unit. Staff in the unit provided many services available to inpatients without the need for the patient to be admitted. We were told this had improved flow into the acute medical unit. The SDEC unit also provided routine appointments, such as blood and scan reviews, for patients who might have had a delayed discharge while awaiting these reviews. The unit was open every Sunday and provided a safety net for patients that might otherwise have had a readmission at the weekend. Staff told us patients on the acute medical unit were able to be safely discharged with the knowledge that there was a service every Sunday for patients requiring urgent attention.

The leadership team had commissioned a project, by an independent company, to improve flow. They acknowledged that, at times, certain wards were being used as places of escalation and this could be addressed if they improved the allocation of beds according to demand. We were told staff within the SDEC unit were involved with the project.

Managers and staff worked to make sure they started discharge planning as early as possible.

We were told all patients had a discharge pathway and worked with discharge facilitators. Staff said there was good connection from the front door to the ward, and visibility of where people were. Staff spoke of more collaborative working for discharge and issues with leaving hospital being better challenged.

The service employed patient flow coordinators to support the discharge planning process. They attended daily ward rounds and bed meetings. Potential tension areas with patient discharges were escalated during these meetings. Staff worked collaboratively with the social care team, who were on site, and this assisted with improved discharges. We were told the main reasons for delayed discharges were community care provision and transport.

We saw boards with planned discharge dates, which were updated regularly at bed meetings, board rounds and multidisciplinary meetings. Patient we spoke with, or their family members, were aware of their planned discharge date and any reasons for delay. Patients, or their family members, told us they felt informed at all stages.

Managers worked to minimise the number of medical patients on non-medical wards. Demand for inpatient beds was outweighing capacity, and escalation areas were being used frequently. Patient areas were identified to be used temporarily to increase capacity, areas of bed escalation used were surgical wards.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. There was a management plan for outliers and staff were aware of where these patients were within the hospital. There was a dedicated medical outlier team who reviewed medical patients on non-medical wards. It was a relatively new team, of three months, but we were told the team worked effectively. Each day at board rounds the multidisciplinary team identified patients who were medical outliers and these patients were then discussed at the leadership and flow meeting.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. There were bed meetings three times a day led by the director of the day. We observed a number of bed meetings and found the meetings to be efficient and collaborative. There were discussions on how many empty beds were available in the hospital, the number of admissions and planned discharges and patients requiring repatriation. Medical outliers, transport and pharmacy delays were also discussed.

Ward sisters and matrons attended daily leadership and flow meetings to consider staffing and flow, for example, any barriers to discharges. The bed manager presented the current position within the hospital and discussions of availability of beds.

Staff acknowledged delayed transfers of care were frustrating. The main reasons for delays were patients who required care from two care workers and securing the appropriate care either at home or in the community. Patients with challenging behaviour often had delayed transfers of care due to there being insufficient community environments they were able to move to. However, we were told social care input had improved due to the social care team working from the hospital.

Discharges between September 2019 and January 2020, where patients were discharged beyond the date of being medically fit for discharge, was on average 20-25 patients per week. The barriers to discharge were waiting for packages of care or bed availability in the community. Delayed discharges and discharge plans were discussed daily at the morning multidisciplinary meeting and escalated through the complex discharge team.

The trust had a plan based on the national framework Operational Performance Escalation Level (OPEL) to respond to increased pressures in demand or surges. The OPEL level was set based on triggers and was updated every two hours, seven days a week on an electronic system.

The hospital had a discharge lounge which was open between 8am and 8pm Monday to Friday. The discharge lounge could provide space for eight patients, although we were told the lounge was rarely used to capacity. Staff had access to clothing for patients who did not have clothes to return home in. Staff provided patients with nutrition and hydration when requested. Patients could wait in the discharge lounge for their relatives or for transport. When the trust was in escalation (declared internal critical incident), patients could go to the discharge lounge without their medicines being ready, and the discharge lounge nursing staff would co-ordinate the provision of medicines prior to them being sent home. This helped to move patients who were medically fit from the wards, so beds could become available. We were told the main reason for delayed discharge from the discharge lounge was transport and pharmacy not having their take home medicines ready.

Average length of stay

Royal Hampshire County Hospital

Managers and staff worked to make sure patients did not stay longer than needed. However, although medical elective (i.e. planned) patients had a shorter length of stay than the England average, medical non-elective (i.e. planned) patients had a longer length of stay than the England average.

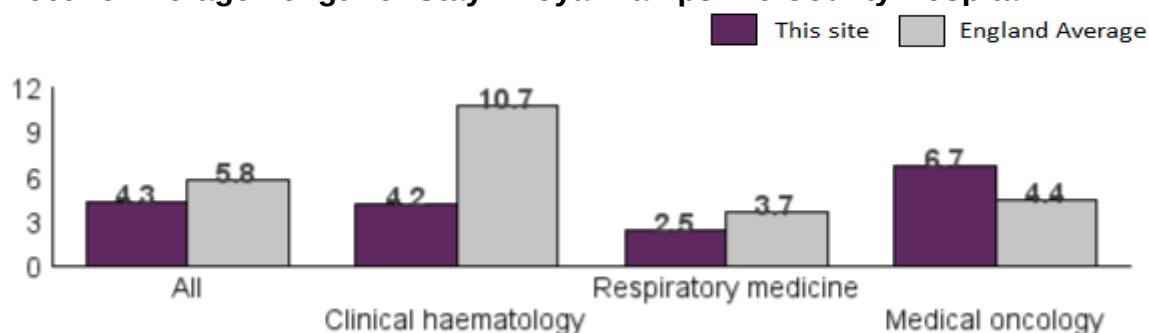
From July 2018 to June 2019, the average length of stay for medical elective patients at Royal Hampshire County Hospital was 4.3 days, which was lower than England average of 5.8 days.

For medical non-elective (i.e. unplanned) patients, the average length of stay was 7.1 days, which was higher than England average of 6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical haematology and respiratory medicine was **lower** than the England average
- Average length of stay for elective patients in medical oncology was **higher** than the England average

Elective Average Length of Stay - Royal Hampshire County Hospital



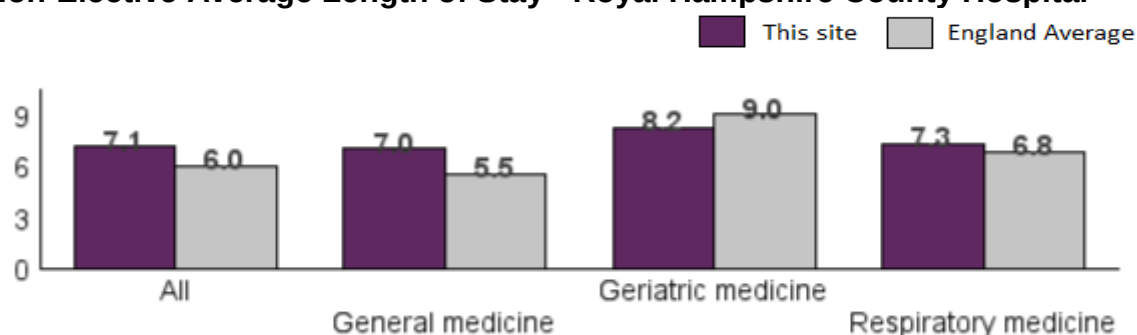
Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective (i.e. unplanned) specialties:

- Average length of stay for non-elective patients in general medicine and respiratory medicine was **higher** than the England average

- Average length of stay for non-elective patients in geriatric medicine was **lower** than the England average

Non-Elective Average Length of Stay - Royal Hampshire County Hospital



Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) – by specialty

Seven specialties were above the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
General medicine	100%	96.3%
Geriatric medicine	100%	96.5%
Thoracic medicine	100%	93.9%
Rheumatology	99.2%	94.3%
Neurology	98.9%	88.8%
Gastroenterology	97.9%	92.1%
Cardiology	89.4%	80.5%

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Dermatology	65.7%	80.2%

(Source: NHS England)

Patient moving wards per admission

From October 2018 to September 2019, within the top five medical wards at the trust, 82.3% of patients did not move wards during their admission and 17.7% moved once or more. The highest percentages of patients moving wards once or more were within wards F3 (26.7%), F2 (24.2%) and F1 (18.3%), all located at Basingstoke and North Hampshire Hospital.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From October 2018 to September 2019, there were 97 patients moving wards at night within medicine. The highest number of ward moves at night was reported by Clifton ward.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Managers monitored to keep patient moves between wards/services to a minimum and the service moved patients only when there was a clear medical reason or in their best interest. We saw a

clear improvement in the number patient moving wards at night. Out-of-hours moves remained a focus for the service and data requested after the inspection demonstrated a decline in out-of-hours moves between June to September 2019. Data showed the number of out-of-hours moves in September 2019 was 17, down from 23 in September 2018.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Staff were encouraged to resolve complaints on the wards. Staff told us poor communication was usually the reason for the complaint and "...it is everyone's responsibility to improve communication".

We saw ward boards displaying 'you said, we did' with evidence of action to improve the service. Information leaflets on how to contact the patient advice and liaison service and how to make a complaint were available on the wards. An easy to read version of the how to make a complaint leaflet was available on the trust website.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, patient stories were used as part of student or staff training.

The service did not always respond to complaints within the timeframe set out in the trust's policy.

From October 2018 to September 2019, there were 66 complaints about medicine at Royal Hampshire County Hospital. The hospital took an average of 28 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be investigated and closed within 25 working days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Communication	19	28.8%
Admissions and discharges	13	19.7%
Patient care	12	18.2%
Clinical treatment	10	15.2%
Values and behaviours	5	7.6%
Other	2	3%
Access to treatment and drugs	1	1.5%
Consent	1	1.5%
End of life care	1	1.5%
Prescribing	1	1.5%
Trust admin/policies/procedures	1	1.5%
Total	66	100%

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

Number of compliments made to the trust

From October 2018 to September 2019, there were 60 compliments about medicine at the trust. A breakdown of compliments by site is below.

Site	Number of compliments	Percentage of total
Basingstoke and North Hampshire Hospital	25	50%
Royal Hampshire County Hospital	25	50%
Total	50	100%

There were 10 compliments received that were not site specific.

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

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The medical care core service was managed by the trust's medicine division. The medicine divisional board consisted of a medical director, operations director and a nursing director.

The nursing director role was introduced in recent years. Several staff we spoke with across the service referred to this role as being instrumental in many of the improvements that had been made. Staff said the role provided leadership for matrons and ensured the views of nursing staff were heard at the top of the service.

The different medical specialities and departments sitting within the division were managed in clusters by clinical directors who sat beneath the medicine division board. Staff we spoke with told us the new members of the medicine divisional board were keen to listen and learn from staff in the service.

Leadership at the divisional and departmental levels were mostly stable, although two members of the divisional management team had been recently appointed at the time of our inspection.

The medical services management team worked well together and brought an effective mix of skills, knowledge and experience to the team.

The care group maintained the quality of leaders throughout the service by effectively reviewing performance against objectives. Clinical directors and departmental managers regularly reported and presented to the divisional management team about the performance of their respective areas of responsibility.

Leaders understood the challenges to quality and sustainability and identified the actions needed to address them. Leaders were open and transparent about their challenges, and the challenges they identified matched the issues raised with us by staff.

The trust had an organisational development and leadership strategy for developing its leaders, which was developed with input from staff and partner organisations.

Leaders throughout the medical services division identified staffing and estates as some of the biggest challenge facing the service.

Leaders identified actions being taken to address the challenges to quality and sustainability. Leaders were working together – as well as with staff, patients and other stakeholders – to address these challenges.

Leaders were visible and accessible. The divisional management team split their time between the trust sites, ensuring they were physically based at Royal Hampshire County Hospital for parts of the week. Leaders also used technology, including videoconferencing facilities, to ensure a visible and accessible leadership across the trust's three sites. We saw photos and contact details of the senior divisional management team in the areas we visited on our inspection of Royal Hampshire County Hospital.

An operational director and matron of the day was in place at each of the trust's two main sites including Royal Hampshire County Hospital. Staff we spoke with said this offered local leadership, accountability and support.

The leaders of the medicines division were carrying out regular walkarounds throughout the service to be more visible and accessible to staff, and to offer staff the opportunity to feedback on what was working well and what may be improved. Staff we spoke with about with about this were positive about efforts to engage with staff in the service.

Staff we spoke with knew who their managers and leaders were and were able to access them when needed. They found them to be supportive and approachable. Leaders also made themselves visible and accessible to staff through regular meetings, including governance and performance meetings.

Vision and strategy

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

The service had a clear vision which was effectively communicated to staff. It was to provide outstanding care for every patient. A strategy was in place to achieve this vision which emphasised the need to do this in a sustainable way in partnership with local and regional partners.

Staff knew and understood what the vision, values and strategy were, and their role in achieving them. Staff we asked were able to tell us the trust's values of CARE: compassion, accountable, respect, and encouraging. We saw the trust's vision and values prompted in communications including posters throughout areas of the hospital we visited.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt respected, supported and valued by colleagues and patients. Most staff we spoke with felt positive and proud to work for the hospital. They expressed motivation and enthusiasm for the future of the service.

We observed cooperative, supportive and appreciative relationships among staff. We observed staff proactively support and communicate politely with each other. A member of staff told us, *"When I require assistance from another member of staff, I look at who is available with the required skills, irrespective of the person's professional background or seniority – it could be an occupational therapist, a physiotherapist, or even a doctor."*

Another member of staff who had returned to work told us they *"returned to this place because I always loved working here and there was always a good team spirit. When I returned I found the place had improved further."*

The trust recognised staff success through a recognition scheme. Patients, visitors and staff were invited to nominate an individual member of staff or a team for their hard work.

The culture centred on the needs and experience of people who use services. All staff spoke positively about the focus being on patients and wanting to provide 'over and above care' every day. A member of staff we spoke with told us the trust's vision to "provide outstanding care for every patient" influenced everything they did.

Action was taken to address behaviour and performance inconsistent with the medicine division's vision and values, regardless of their position. We witnessed examples of staff challenge each other for conduct falling below what was expected.

The culture in the medicine division sought to encourage openness and honesty, including with service users in response to incidents. Staff received training on, and understood, the duty of candour. We saw examples of staff applying the duty of candour in response to incidents in incident investigation reports we reviewed.

Staff we asked were aware of the trust's freedom to speak up guardians, who provided independent and impartial support to workers to speak up. Staff were confident about speaking up to their managers or senior leaders, confident they would be listened to and action taken if appropriate. Staff were also able to use the trust's, 'Speak In Confidence' system to speak up (anonymously if they wished) with the chief nurse or chief executive.

There was an emphasis on the safety and wellbeing of staff. The trust's appraisal programme had been recently reformed at the time of our inspection to give greater weight to the wellbeing of staff. The new programme included more regular, informal meetings in between annual appraisals to check in with staff. Staff were also able to access the trust's Staff Health and Wellbeing Team which, among other things, provided occupation health services.

Equality and diversity were promoted within the organisation. Staff in the medicine division were encouraged to, and did, take part in the trust's reverse mentoring scheme. This scheme paired up black, Asian and ethnic minority staff, typically from lower bands, to mentor leaders and offer insights into different lived experiences.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, leaders did not always operate effective governance processes, throughout the service.

Specialities or business units within the division held regular governance meetings, as well as monthly mortality and morbidity reviews. Minutes and learning from these minutes were stored on shared drives as well as being shared with the trust-level governance team to allow learning for those who were not able to attend these meetings. However, senior leaders explained that minutes from mortality and morbidity review meetings across the division were not standardised. This meant the ability to learn from these minutes was potentially not as effective.

Speciality or business unit level meetings fed into monthly divisional governance meetings. These meetings were an opportunity for the divisional management team to discuss, challenge and support matrons, clinical directors and other leaders on a range of issues, including moderate/serious risks and patient experience information.

The senior divisional management team also held monthly divisional performance review meetings with speciality or business unit-level management teams.

The divisional management team, in turn, reported up the trust management team in a number of ways including reporting on its performance every quarter to the quality and performance committee, which went to the trust executive team.

We reviewed the division's October 2019 report to the committee. The purpose of the report was to provide assurance regarding the division's quality performance highlight areas of good performance and, where required, escalate areas of concern. The quarterly report to the committee covered a range of issues including serious incidents, staffing and feedback from patients. However, the report lacked detail in many areas including, for example, when it referred to the audits undertaken by the division but did not provide detail on the division's performance in these audits. This raised questions about the reports ability to fulfil its stated aim of providing assurance to the quality and performance committee regarding the performance of the medicine division.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The medicine division held a comprehensive risk register across the division. Most of these risks were held and managed locally (e.g. at the business unit level) and were reviewed monthly by the senior divisional management team at divisional performance reviews meetings.

The divisional risk register was reviewed quarterly by the senior leadership team of the medicine division.

According to the division's quarterly report to the quality and performance committee in October 2019, the top risks on the divisional risk register were: the limited and ageing catheterisation laboratory facilities in the trust; insufficient capital funding to replace and maintain equipment and the environment; staffing levels; not achieving its financial, operational expenditure plan; and failing to meet cancer targets. These matched the top risks identified by senior leaders we spoke with on inspection.

Staff had access to the risk register at a speciality/business unit or divisional level and were able to escalate concerns as needed effectively. Leaders on the wards and within specialties had a good understanding of their risks and how to manage them.

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or disruption to business continuity. Staff we spoke with were aware of these plans and training was being delivered to ensure staff were equipped to deal with such events.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There was a holistic understanding of performance across the division. Leaders used the performance dashboard and assurance reports to access and assess the most recent data. This included all relevant metrics. This intelligence was used to make day-to-day operational decisions as well as improvements where this was possible.

Staff including leaders were able to find the information they needed to support them with their role. This included information on patient safety metrics.

Matrons and other senior leaders in the service had a clear, daily view of staffing. Matrons and relevant managers were informed of all patient safety incidents reported. Managers could access up to date information regarding mandatory training compliance of individual staff members. Senior staff expressed confidence in the quality of the data.

The service submitted data and notifications as required to external organisations.

Engagement

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

Leaders actively engaged with staff to plan and manage services. We heard of service leaders regularly visiting different areas of the service to seek feedback from staff across all professional backgrounds on what worked well and what could be improved.

Monthly meetings were arranged, bringing groups of staff from across the whole trust together to offer staff the opportunity to reflect, discuss challenges, and how to address them. This included a monthly meeting of matrons and senior nursing staff across the trust. Similarly, the division held strategy away days bringing together senior staff including matrons, clinical leads, directors and others to discuss improvement plans.

Staff were encouraged to make suggestions for improvement. The service had an active quality improvement programme, discussed later in this section of this report, involving staff across all professional backgrounds.

Service users, those close to them and their representatives were encouraged to provide feedback to shape the service. Staff shared examples of how they have worked with patients to improve the service, including installing additional shower and toilet facilities in some of the wards in response to feedback from patients.

Matrons across the service regularly met groups of patients to discuss patients' experiences and identify themes.

However, leaders of the medicine division acknowledged public engagement needed a more formalised approach, and said work was underway to formalise this programme. The trust was holding workshops attended by patients to develop a patient experience and engagement strategy, with a focus on understanding what mattered to patients and the most effective ways to engage and involve patients.

Learning, continuous improvement and innovation

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

Leaders and staff strove for continuous learning, improvement and innovation. This included participating in appropriate research projects and recognised accreditation schemes. Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented.

Innovating for the future was one of the trust's key priorities for the year of 2019/20, and this included prompting its Quality Improvement (QI) programme. Leaders across the medicine division explained staff from across all backgrounds regardless of seniority were invited to become QI practitioners to make changes to the way the service (and even the wider trust) worked and improve the care provided to patients.

We found many examples of learning on our inspection of the medical care core service at Royal Hampshire County Hospital. As mentioned earlier in this report, staff had made changes to the practice of using catheters in response to evidence their use increased risks of infection and loss of bladder control. The multidisciplinary team based across Twyford and Clarke ward were also delivering a quality improvement project to ensure acute stroke patients were admitted to the ward as quickly as possible and no later than their target of 4 hours. This was based on evidence showing stroke sufferers had a better chance of being restored to their former level of functioning if treatment was started early.

Many members of staff we spoke with told us about how demand outstripping bed availability was one of the main challenges for the service. This pressure on beds often resulted in medical patients being moved to (i.e. 'outlying' in) other, often surgical, wards. At the time of our inspection, the service had launched a winter pressures contingency plan which involved appointing a single medical consultant (supported by junior doctors) to be responsible for reviewing medical patients outlying on non-medical wards. This plan sought to achieve medical patients outlying on other wards received appropriate and timely medical consultant input in their care. Staff we spoke with were positive about this new process.

Surgery

Facts and data about this service

The trust runs a range of surgical services for inpatient and day case procedures including urology and (peritoneal lining of the abdominal cavity) malignancy (cancer) as well as services for hepatobiliary, upper gastrointestinal, colorectal, ear nose and throat, ophthalmology, orthopaedics, oncology, maxiofacial and oral surgery.

Royal Hampshire County Hospital

Royal Hampshire County Hospital provides both elective and non-elective surgical services, including for colorectal, ophthalmology and orthopaedic specialities. The surgical division at this site has the following wards and units:

Ward/unit	Number of beds	Services provided
Anthony Letchworth ward	13	Breast surgery and gynaecology
Wainwright ward	11	Elective surgery ward
Kemp Welch ward	11	Surgery
Kemp Welch ward - SAU	12	Surgery assessment unit
Bartlett ward	27	Emergency orthopaedic ward
St Cross ward	20	Elective orthopaedic ward
Treatment centre/SSSU	20	Day cases and short stay unit
Total	114	

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

Services across the trust were changed in December 2019. Royal Hampshire County Hospital no longer treats trauma patients but continues to provide emergency general surgery. In addition, at the time of the inspection there was no longer a surgical assessment unit and patients on Kemp Welch ward were not surgical patients.

The trust had 36,223 surgical admissions from July 2018 to June 2019. Of these, 10,620 (29.3%) were emergency admissions, 20,105 (55.5%) were day case, and the remaining 5,498 (15.2%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life

support training to all staff and made sure everyone completed it.

Mandatory training completion rates

A breakdown of compliance for mandatory training courses from April to September 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Counter fraud	463	475	97.5%	90%	Yes
Dementia awareness (including privacy and dignity standards)	462	475	97.3%	90%	Yes
Equality and diversity	453	475	95.4%	90%	Yes
Health and safety (slips, trips and falls)	453	475	95.4%	90%	Yes
Conflict resolution	434	475	91.4%	90%	Yes
Moving and handling	429	475	90.3%	90%	Yes
Information governance	434	475	91.4%	95%	No
Fire 1 year	423	475	89.1%	90%	No
Basic life support	365	429	85.1%	90%	No
Immediate life support	365	429	85.1%	90%	No
Infection control	360	475	75.8%	90%	No
Medicine management training	252	475	53.1%	90%	No

In surgery the 90% target was met for six of the 12 mandatory training modules for which qualified nursing staff were eligible. Nursing staff did not meet the 95% target set for the module information governance.

A breakdown of compliance for mandatory training courses from April to September 2019 at trust level for medical staff in surgery is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality and diversity	240	296	81.1%	90%	No
Health and safety (slips, trips and falls)	239	296	80.7%	90%	No
Moving and handling	228	296	77.0%	90%	No
Conflict resolution	227	296	76.7%	90%	No
Counter fraud	214	296	72.3%	90%	No
Dementia awareness (including privacy and dignity standards)	201	296	67.9%	90%	No
Basic life support	200	296	67.6%	90%	No
Immediate life support	200	296	67.6%	90%	No
Fire 1 year	200	296	67.6%	90%	No
Infection control	193	296	65.2%	90%	No
Information governance	151	296	51.0%	95%	No

Medicine management training	14	296	4.7%	90%	No

In surgery the 90% target was not met any of the mandatory training modules for which medical staff were eligible. Medical staff did not meet the 95% target set for the module information governance.

Royal Hampshire County Hospital

A breakdown of compliance for mandatory training courses from April to September 2019 for qualified nursing staff in surgery at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Counter fraud	181	184	98.4%	90%	Yes
Health and safety (slips, trips and falls)	179	184	97.3%	90%	Yes
Dementia awareness (including privacy and dignity standards)	178	184	96.7%	90%	Yes
Equality and diversity	176	184	95.7%	90%	Yes
Fire 1 year	166	184	90.2%	90%	Yes
Information governance	166	184	90.2%	95%	Yes
Conflict resolution	165	184	89.7%	90%	No
Moving and handling	161	184	87.5%	90%	No
Basic life support	127	157	80.9%	90%	No
Immediate life support	127	157	80.9%	90%	No
Infection control	141	184	76.6%	90%	No
Medicine management training	93	184	50.5%	90%	No

In surgery the 90% target was met for six of the 12 mandatory training modules for which qualified nursing staff at Royal Hampshire County Hospital were eligible. Nursing staff did not meet the 95% target set for the module information governance.

A breakdown of compliance for mandatory training courses from April to September 2019 for medical staff in surgery at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Health and safety (slips, trips and falls)	106	126	84.1%	90%	No
Conflict resolution	102	126	81.0%	90%	No
Moving and handling	101	126	80.2%	90%	No
Equality and diversity	100	126	79.4%	90%	No
Counter fraud	97	126	77.0%	90%	No
Dementia awareness (including privacy and dignity standards)	85	126	67.5%	90%	No
Infection control	83	126	65.9%	90%	No
Basic life support	81	126	64.3%	90%	No
Immediate life support	81	126	64.3%	90%	No

Fire 1 year	81	126	64.3%	90%	No
Information governance	70	126	55.6%	95%	No
Medicine management training	9	126	7.1%	90%	No

In surgery the 90% target was not met for any of the mandatory training modules for which medical staff at Royal Hampshire County Hospital were eligible. Medical staff did not meet the 95% target set for the module information governance.

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

Departments and wards we visited during the inspection showed better compliance with mandatory training. For example, on Wainwright ward we saw 91% compliance. Managers explained that a new computer system was now used to monitor mandatory training compliance which was more accurate than the old system. We saw staff who were not compliant with mandatory training had been identified and been allocated time to complete it.

We reviewed, more recent data supplied to us by the trust showed that as of 31 December 2019 a compliance of 89% of all medical and nursing staff at Royal County Hospital, which was almost equal to the trust target. The treatment centre theatres had the best overall compliance of 99.5% and one of the worst areas of compliance was amongst general surgical junior doctors with 69% compliance.

The mandatory training was comprehensive and met the needs of patients and staff. In theatres mandatory training sessions were undertaken at monthly audit meetings.

The trust provided training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia, but not all staff had completed the training. However, staff we spoke to had a good understanding on caring for patients with mental health needs, learning disabilities, autism and dementia.

Managers checked mandatory training and alerted staff when they needed to update their training. Meeting minutes we reviewed showed senior leaders regularly checked training rates.

The trust used an online training system for keeping a record and completion of mandatory training which was accessible to staff and managers. The application could be downloaded by staff who could then access their mandatory training record and complete mandatory training remotely. The system alerted staff and managers when training was due to expire. Staff we spoke to were positive about the system.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had completed safeguarding training, but staff knew how to recognise and report abuse.

Staff knew how to identify patients at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they didn't often have to raise safeguarding concerns but were able to give us examples of different types of abuse or suspected abuse they would report.

Staff in theatres explained how every patient had a full body tissue viability assessment before returning to the ward. This identified any areas of tissue damage or any other injuries such as bruising which was then documented within the patient's medical record and reported as a safeguarding or incident.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April to September 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	448	475	94.3%	90%	Yes
Safeguarding children (level 1)	441	475	92.8%	90%	Yes

In surgery the 90% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April to September 2019 at trust level for medical staff in surgery is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	207	296	69.9%	90%	No
Safeguarding children (level 1)	190	296	64.2%	90%	No

In surgery the 90% target was not met for either of the safeguarding training modules for which medical staff were eligible.

Royal Hampshire County Hospital

A breakdown of compliance for safeguarding training courses from April to September 2019 for qualified nursing staff in surgery at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	173	184	94.0%	90%	Yes
Safeguarding children (level 1)	162	184	88.0%	90%	No

The 90% target was met for one of the two safeguarding training modules for which qualified nursing staff in surgery at Royal Hampshire County Hospital were eligible. A breakdown of

compliance for safeguarding training courses from April to September 2019 for medical staff in surgery at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	98	126	77.8%	90%	No
Safeguarding children (level 1)	84	126	66.7%	90%	No

The 90% target was not met for either of the safeguarding training modules for which medical staff in surgery at Royal Hampshire County Hospital were eligible.

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

We asked the trust to supply us with compliance with level two and level three adult and children safeguarding training. As of 31 December 2019, 94% of doctors had completed level two adult safeguarding training and 92% of nurses had completed the training. Seventy three percent of doctors and 90% of nurses had completed level two children safeguarding training. Data supplied was across the surgical division.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Improvements had been made in infection prevention and control standards since our last inspection. In theatres and on Wainwright ward we saw that resuscitation equipment was free from dust, open waste bins had been replaced with foot operated lid closure bins and no boxes were stored on the floor or on top of cupboards. In addition, on Wainwright ward we saw that the walls had been re-decorated, where peeling paint was found at the last inspection.

All staff were 'bare below the elbows' in clinical areas to allow effective handwashing in line with national guidelines and trust policy. This was an improvement since our last inspection when not all staff were 'bare below the elbows' in clinical areas.

Hand hygiene audit results were displayed in clinical areas. For example, audit results for St Cross ward and Nightingale theatres showed 100% compliance for November and December 2019.

Staff followed infection control principles including the use of personal protective equipment. In the operating theatres, staff wore scrub suits and theatre caps in line with trust policy.

The theatres underwent an annual assessment by an external company, this provided assurance that the theatre ventilation was working correctly to minimise the risk of cross infection. We reviewed the schedule which showed all theatres had undergone an assessment and passed within the last 12 months. The orthopaedic theatres with an ultra-clean ventilation system were regularly tested to test the ventilations efficacy. We reviewed the reports which showed when issues were found action was taken to address the issues.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned and ready to use. This was in line with the trust's infection control policy.

We reviewed cleaning checklists for theatres, the wards and departments which provided assurances staff had completed daily and weekly cleaning tasks. We saw these were fully completed at the correct time intervals.

Monthly cleaning audit results provided assurances around the cleanliness of theatres and wards. For example, audit results showed 92% compliance on Bartlett ward in September 2019. The trust considered that a compliance of over 87% was fully compliant.

The trust met National Specifications for Cleanliness in the NHS about the frequency of audits in very-high risk areas such as theatres. The specifications state that all very high-risk areas should have weekly audits. Weekly audits undertaken in theatres between 4 January 2020 and 19 January 2020 showed 100% compliance for Nightingale theatres and for two weeks 100% compliance and one week 98% compliance in the treatment centre theatres.

Since our last inspection staff undertook monthly quality assessment checks of wards and departments, which included a variety of checks. The checks included aspects of infection prevention and control. Checks included; was there hand gel sanitiser available, were all staff 'bare below the elbows', rubbish and linen stored correctly and is the environment clean and well maintained. We reviewed some of these completed quality assessments and saw that action was taken when areas of non-compliance were found. For example, in the Nightingale theatres one of the hand sanitiser dispensers was empty and we saw action had been taken to re-fill it.

Staff worked effectively to prevent, identify and treat surgical site infections. The service worked to prevent hospital-acquired infections and screened patients for Meticillin-resistant Staphylococcus aureus before surgery. The pre-assessment appointment included swabs to test for Meticillin-resistant Staphylococcus aureus this could then be treated before surgery if the results came back positive.

This hospital was one of the 20 surgical units taking part in the reduction of surgical site infection using novel intervention (ROSSINI) trial. The trial was to show whether the use of a wound-edge protection device in adult patients undergoing abdominal surgery lead to a lower rate of surgical site infection. Wound edge protection devices protect the edges of the wound surgery. We saw posters in theatres displaying details of the audit for staff and which type of patients were eligible for the trial and who to contact if they had any questions.

The surgery performance dashboard showed trust wide within surgery there were no cases of Meticillin-resistant Staphylococcus aureus bacteraemia (bloodstream infection) in the period January 2019 to December 2019. There were nine hospital acquired Clostridium difficile infections trust wide within surgery and 30 across the whole trust (C. diff; a bacterium that can infect the bowel and cause diarrhoea). This was less than tolerance level set by NHS England and Public Health England. In the same time period there were two Methicillin-sensitive Staphylococcus aureus blood stream infections trust wide within surgery.

The service followed Public Health England's national 'Protocol for the Surveillance of Surgical Site Infection'. The most recent surgical site infection data provided by the trust showed an infection rate of 1.6% for repair of fracture neck of femurs (hip joint) in the period July 2019 to September 2019. This infection rate was slightly higher when compared to other hospitals. There was no data available for hip and knee replacements as less than 95 operations were performed in the time period.

Patients with transmittable infections were cared for in side rooms to reduce the risk of cross infection. Signs were on the doors to alert colleagues and visitors to the risk of infection. Personal protective equipment and hand sanitiser gel were available outside side rooms.

The service had an onsite facility for the sterilisation of surgical instruments. The service had a four-hour target turnaround times for instruments. Theatre staff told us there were no issues obtaining instruments.

The trust took part in Patient-led assessments of care environment (PLACE). These were annual assessments involving local people who went into hospitals to assess how the environment supported the provision of care. The November 2019 PLACE inspection showed that Kemp Welch and Wainwright wards passed all elements assessed for cleanliness of equipment and the environment.

Environment and equipment

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

Improvements and repairs to the equipment and environment had been undertaken since our last inspection. Non-ligature hooks had been removed, broken equipment had been replaced, bariatric equipment was available, and emergency equipment was checked consistently.

Not all wards were secure to prevent unauthorised access to the ward. We saw Wainwright ward doors were open and unable to lock. All other wards and departments had electronic swipe card access or visitors were required to press a buzzer to obtain access.

Staff carried out daily safety checks of specialist equipment. In theatres, we saw specialist equipment such as difficult intubation trolleys were checked daily against the checklist to ensure equipment was available and fit for use.

The service had enough suitable equipment to help them to safely care for patients. Bariatric equipment such as chairs were available in wards and departments other bariatric equipment was available on request from the hospital's equipment department. The Nightingale theatres had a specialist inflatable transfer mattress used for transferring bariatric patients from the bed to the operating table.

The service tested equipment to provide assurances around function and electrical safety. Equipment was labelled to show when it was last tested. We checked 20 different pieces of equipment across wards, departments and theatres all had passed an electrical safety test within the last 12 months.

Staff checked and maintained emergency resuscitation equipment, to ensure it was available and fit for use in an emergency. We checked emergency resuscitation trolleys in recovery, treatment centre and the surgical wards. Records showed staff completed daily and weekly checks, providing assurances the trolleys were safe. We checked sterile items and medicines within the trolleys and all were within the manufacturer's expiry dates. All trolleys were fitted with a tamper evident tag. Issues with resuscitation trolleys found at the last inspection such as them not being clean and inappropriate storage of oxygen cylinders had been resolved.

Disposable equipment for once-only use was safe to use. We checked 12 random items and all packaging was intact and items were within manufacturer's expiry dates.

Staff disposed of clinical waste safely. Staff correctly segregated clinical and non-clinical waste into different coloured bags. This was in line with national guidance. Staff used designated recycling bins for disposal of recyclable non-clinical waste to help the environment. In theatres

there was a sustainability lead who worked in collaboration with trust's sustainability lead to ensure items that could be recycled were. In addition, they were working with manufacturers to recycle specific items such as oxygen tubing and face masks used to give oxygen to a patient.

The service disposed of sharps items such as needles in line with national guidelines. We checked 13 sharps disposal bins which were correctly assembled, dated and were no more than three-quarters' full.

In the Nightingale theatres and theatres within the treatment centre we reviewed multiple anaesthetic machine log books. These showed that staff had undertaken a safety check of the machines prior to use and was in line with Association of Anaesthetists of Great Britain and Ireland guidelines.

Substances subject to the Control of Substances Hazardous to Health regulations were stored securely to prevent harm. In theatres, flammable items such as inhalation anaesthetics were stored securely with appropriate signage.

The November 2019 PLACE inspection showed that Kemp Welch and Wainwright wards passed all elements assessed for the appearance and condition of the environment.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, staff did not reassess the risk of venous thromboembolism within 24 hours of admission.

We reviewed 14 patient medicine charts which showed all patients were assessed for the risk of developing a venous thromboembolism on admission to hospital. However, none of the charts showed patients had their risk reassessed within 24 hours of admission. This was not in line with National Institute for Health and Care Excellence guideline CG92- reducing the risk for patients in hospital. This did not provide assurance that the risk of patients developing a venous thromboembolism was monitored and preventive measures taken if the risk had increased from admission. Data supplied to us by the trust was consistent with our findings. For example, data showed that from July 2019 to September 2019 venous thromboembolism compliance on Bartlett ward ranged between 52% and 96%. In the same time period compliance varied between 85% and 97% on Kemp Welsh ward.

In theatres there was a safety protocol for the same administration of local anaesthetic blocks.

When anaesthetists prepared the medicines to inject for a local anaesthetic block they used a dedicated yellow tray to put the medicines in. Once prepared they put a yellow lid over the tray with stickers on saying stop before you block. Yellow is the national colour used to identify medicines for use in local anaesthetic blocks to identify they are not for intravenous administration (into a vein). The lid over the top of the tray meant they reduced the likelihood that they could be administered into a vein in error. The lid was removed immediately before the medicines for the anaesthetic block were to be administered, the stickers reminded staff to check the intended site of the block before administration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff used National Early Warning Scores 2 (NEWS2), a recognised tool to identify deteriorating patients, and escalated correctly in line with national guidance. We reviewed

eleven NEWS2 charts which showed staff recorded observations and calculated early warning scores correctly. We saw two examples of when staff had escalated for medical review in line with trust policy and national guidance.

The service undertook monthly audits on use of the NEWS2 tool to ensure staff were recording observations accurately and escalating patients who were deteriorating. Audit data was displayed on wards and showed good compliance with the NEWS2 tool. The trust colour coded compliance with NEWS2; green achieved the standard, yellow partially achieved and red not achieved. Audit data showed varied compliance between October 2019 and January 2020. St Cross ward and Wainwright ward achieved two green ratings and one yellow, Kemp Welch ward achieved two green, one yellow and one red rating and Bartlett ward achieved three red ratings. Not all wards submitted data for all four months.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and mostly reviewed them regularly. A variety of risk assessments were undertaken such as the risk of falls, use bed rails assessments and pressure area risk assessment and malnutrition universal screening tool. We reviewed 16 patient records and found that generally risk assessments were undertaken and reassessed. This was an improvement since our last inspection when risk assessments were not consistently undertaken and recorded. In two electronic patient records we found the reassessment on risks was not recorded. The nurse in charge explained to us that it their responsibility to confirm the reassessments had been undertaken and record it electronically reviewed the bedside records of the same two patients which showed the risks had been reassessed. The nurse in charge explained that sometimes documenting the risks electronically was not completed.

Staff knew about and dealt with any specific risk issues. Specific risks were discussed at handovers for example, if a patient was at high risk of having a fall or developing a pressure ulcer. We saw actions were taken to mitigate identified risks such as the use of pressure relieving equipment to reduce the risk of developing a pressure ulcer.

Elective surgical patients attended a face-to face nurse led pre-assessment clinic to ensure they were medically fit for surgery. Risk assessments, and investigations were undertaken based on national guidelines. Nurses reviewed the results and referred to the weekly anaesthetist led clinic for assessment prior to surgery if needed.

The service used a recognised tool to identify and treat sepsis in line with national guidance. Sepsis is a rare but serious complication of an infection that can lead to multiple organ failure and death if not treated promptly. We saw the trust's "Do Sepsis 6 in 60 minutes" when a NEWS2 score of five or more triggered sepsis screening. Patients suspected to have sepsis or who had sepsis were flagged on their electronic patient record to alert staff. The management for treating sepsis was included on the NEWS2 chart this was in line with national guidelines and gave staff clear guidance on treating sepsis. Staff gave us examples of when they had followed the guidance, there were no surgical patients being treated for sepsis at the time of our inspection.

Theatres followed the World Health Organisation (WHO) Surgical Safety Checklist to ensure patients received their operation safely. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (when the operation is completed) and debrief. We observed all five steps of the WHO checklist, and saw staff fully completed and engaged in all the required checks. This was an improvement since our last inspection when the fifth step (debrief) was not undertaken within the trust. We saw the debrief stage was recorded electronically and included information on what had gone well, and

any issues identified. We reviewed some de-brief records any saw any issues identified were followed up. For example, availability of a radiographer in theatre had caused a delay to the operating list. The team leader had followed this up with the radiology department to find a solution to prevent it happening again.

The service audited compliance with the WHO Surgical Safety Checklist. For example, data collected in the treatment centre in August 2019 showed 100% compliance with steps one to four and 84% compliance with step five (debrief). This showed an improvement since our last inspection when step five was not undertaken.

The service had 24-hour access to mental health liaison and specialist mental health support, if staff were concerned about a patient's mental health. Staff knew how to contact the team for support.

Staff shared key information to keep patients safe when handing over their care to others. We saw a discharge lounge checklist was completed for each patient going to the discharge lounge before being discharged from hospital. This included key information for carer's, relatives or community staff.

The trust used yellow anti-slip socks to enable staff to easily identify patients assessed as being at high risk of falls and provide them with more support. We saw patients with high falls risk wearing yellow anti-slip socks. Patients who were at high risk of falls were discussed at handovers and measures taken to reduce the risk of falls. For example, patients were placed near the staff station, so they could be seen.

The service undertook monthly audits to monitor compliance with falls assessments. For example, Kemp Welch ward achieved 100% compliance between October 2019 and January 2020.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. We reviewed staffing allocations in the Nightingale theatres and the treatment centre and found they were in line with the Association for Perioperative Practice (AfPP) guidelines on staffing levels.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. We reviewed rotas in ward areas which showed mainly actual staffing levels matched planned staffing levels. We saw actual and planned staffing levels were displayed on wards, this meant patients and visitors could see how many staff were on duty.

The service used a safer staffing tool which produced monthly reports to monitor safe staffing levels. Information from the surgical division showed that in September 2019 the average fill rate of day and nights shifts for nurses and health care assistant was above 99%.

The service had a duty matron every day who was able to deal with any staffing shortfalls and move staff around the different wards and departments to ensure safe staffing levels were maintained.

Trust level

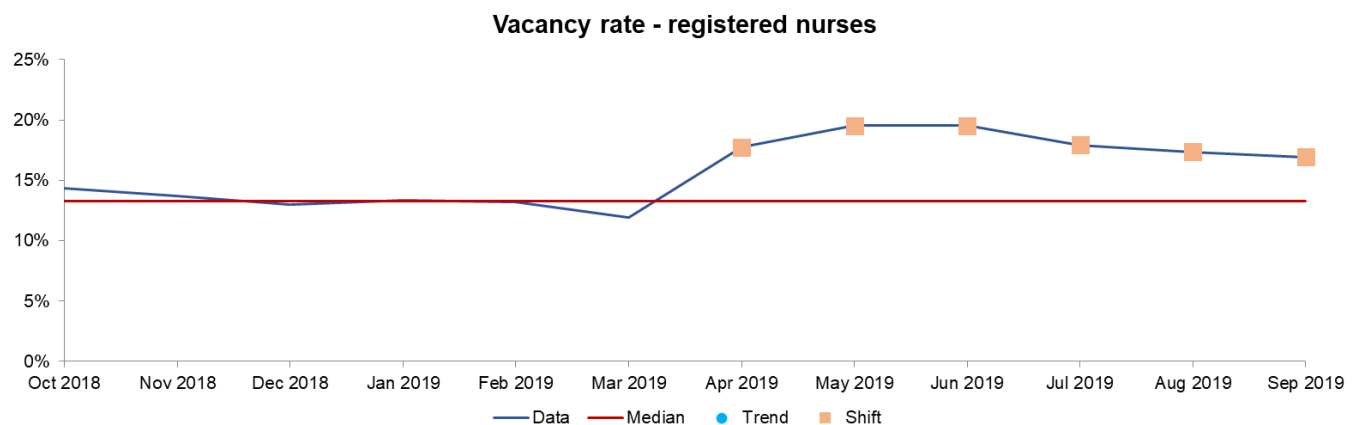
The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

Staff group	Surgery annual staffing metrics						
	October 2018 to September 2019						
	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	1,241	9%	18%	3.7%			
Qualified nurses	496	16%	9%	4.4%	86,654 (9%)	40,457 (4%)	19,055 (2%)

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

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

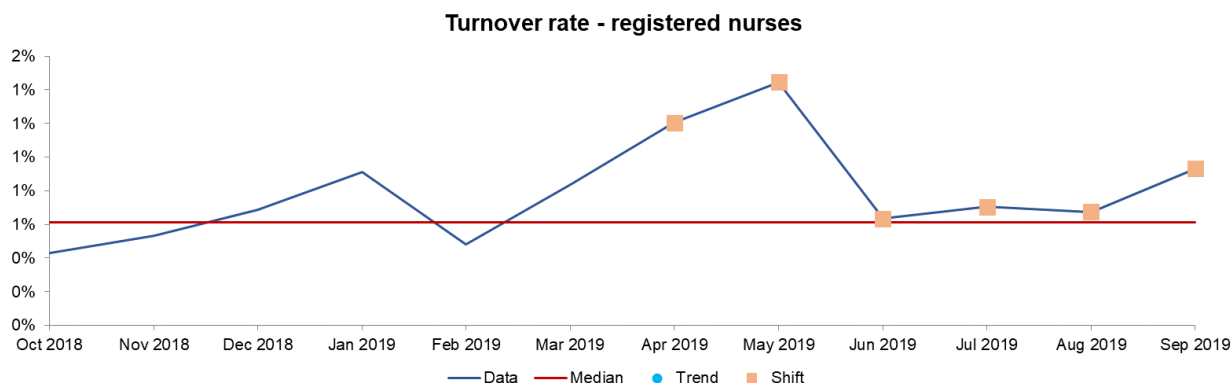
Vacancy rates



Monthly vacancy rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019.

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

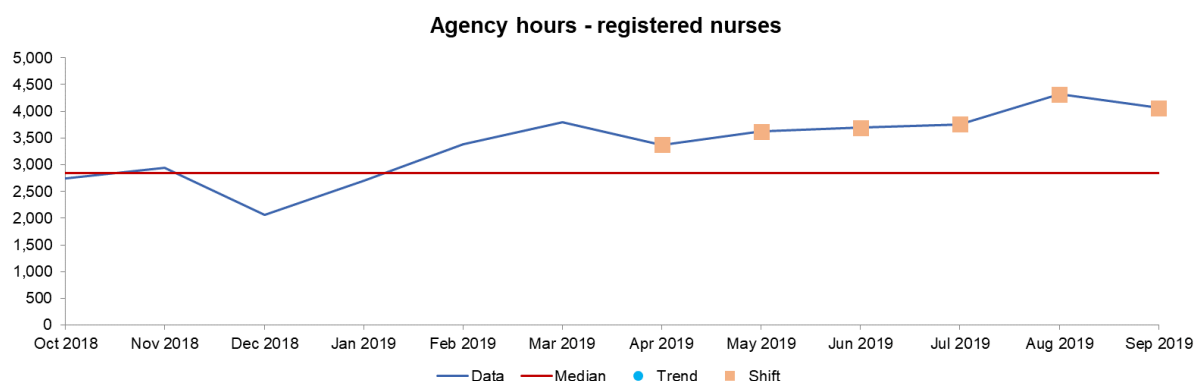
Turnover rates



Monthly turnover rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019. This could be an indicator of change.

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

Agency staff usage



Monthly agency use over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019.

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

Royal Hampshire County Hospital

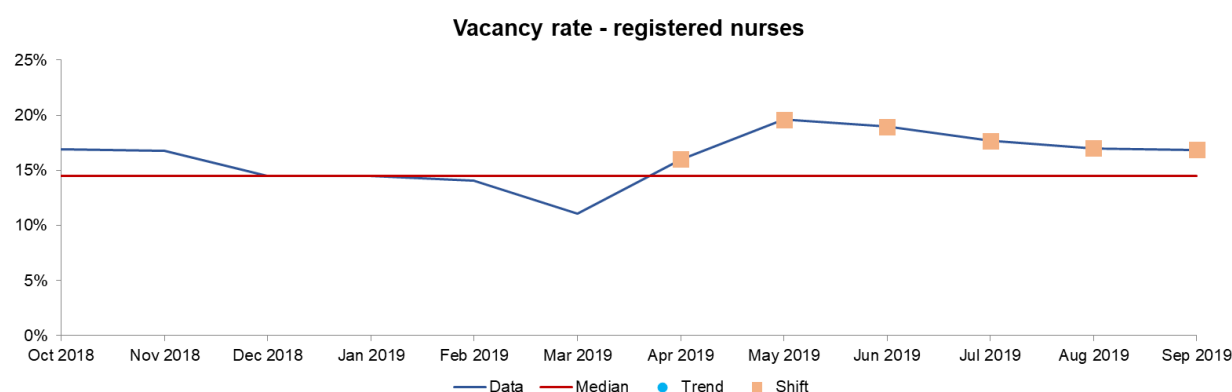
The table below shows a summary of the nursing staffing metrics in surgery at Royal Hampshire County Hospital compared to the trust's targets, where applicable:

Surgery annual staffing metrics							
October 2018 to September 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	368	10%	17%	3.5%			
Qualified nurses	154	16%	9%	4.4%	28,427 (10%)	10,021 (3%)	6,045 (2%)

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

Nurse staffing rates within surgery at Royal Hampshire County Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness.

Vacancy rates

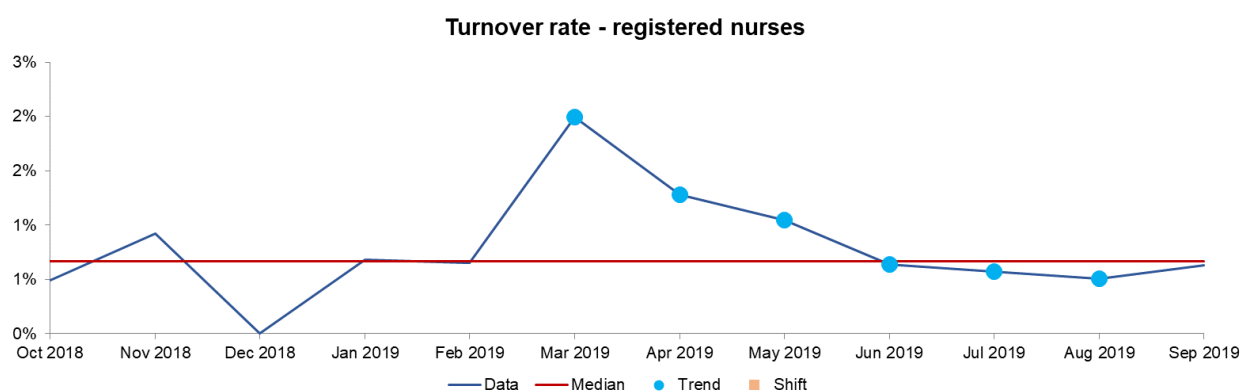


Monthly vacancy rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019.

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

More recent vacancy data supplied to us by the trust showed an overall vacancy rate of 15% within surgery across Royal Hampshire County Hospital and Andover War Memorial hospital of 15%. The area with the highest vacancy (41%) was St Cross ward at Royal Hampshire County Hospital. This was because this ward had increased its bed capacity by four beds as part of the orthopaedic transformation project in December 2019 and therefore the staffing establishment had been increased. The service was currently recruiting to fill these posts. The area with the least amount of vacancies was the pre-assessment unit which had no vacancies.

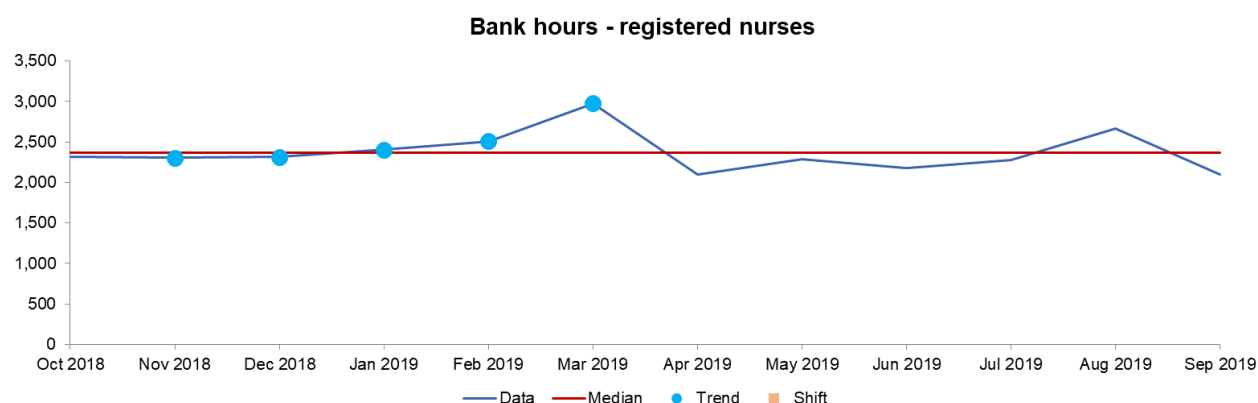
Turnover rates



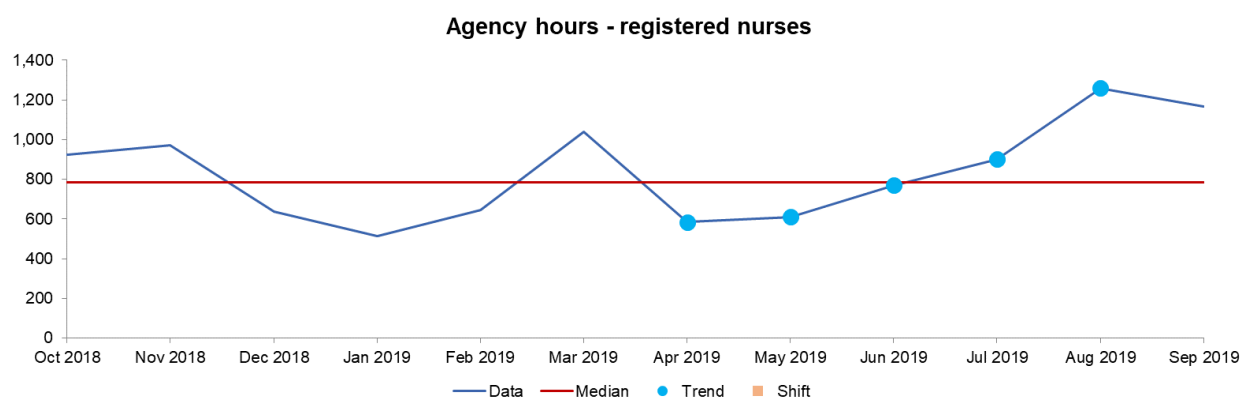
Monthly turnover rates over the last 12 months for registered nurses show a downward trend from March 2019 to August 2019.

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

Bank and agency staff usage



Monthly bank use over the last 12 months for registered nurses show an upward trend from November 2018 to March 2019.



Monthly agency use over the last 12 months for registered nurses show an upward trend from April 2019 to August 2019.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The matron in theatres told us that the same two agency theatre practitioners had booked for several months in advance. This ensured the agency staff were familiar with the environment and the trust's procedures and policies.

Managers made sure all bank and agency staff had a full induction and understood the service. We saw examples of completed inductions for agency staff working within theatres. The induction included where emergency equipment and fire exits were located as well as other useful information.

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

Medical staffing

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

Surgical services were consultant delivered and led. Records showed evidence of daily ward rounds, including review with senior clinicians. Some surgeons worked across two hospital sites.

For example, with the recent orthopaedic transformation project, emergency and elective orthopaedics had been separated so orthopaedic surgeons undertook elective and emergency work at two different sites. The surgical teams were made up of consultants, specialty registrars, senior house doctors and foundation doctors. The majority of anaesthetic consultants only worked at Royal Hampshire County Hospital. Anaesthetic consultants told us that they used to work across different hospitals, but this had not worked logistically so now the majority only worked at one hospital site.

Out of hours, there was one registrar, one senior house officer and one junior doctor, with consultant on-call cover. This was the same for anaesthetic doctor provision.

Doctors in training told us that there were usually two junior doctors covering each ward. They told us that this meant if the ward was not too busy one doctor could go to a different department such as theatres for learning and development.

Nursing staff on the wards told us that doctors were responsive and easy to contact if a patient needed review by a doctor. Medical outliers (medical patients occupying surgical beds) received a daily review by a newly formed outlier team.

Trust level

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust's targets, where applicable. Please note that Hampshire Hospitals NHS Foundation Trust has some medical staff that work across sites and therefore are not allocated to a specific site. These staff are captured under the trust level figures.

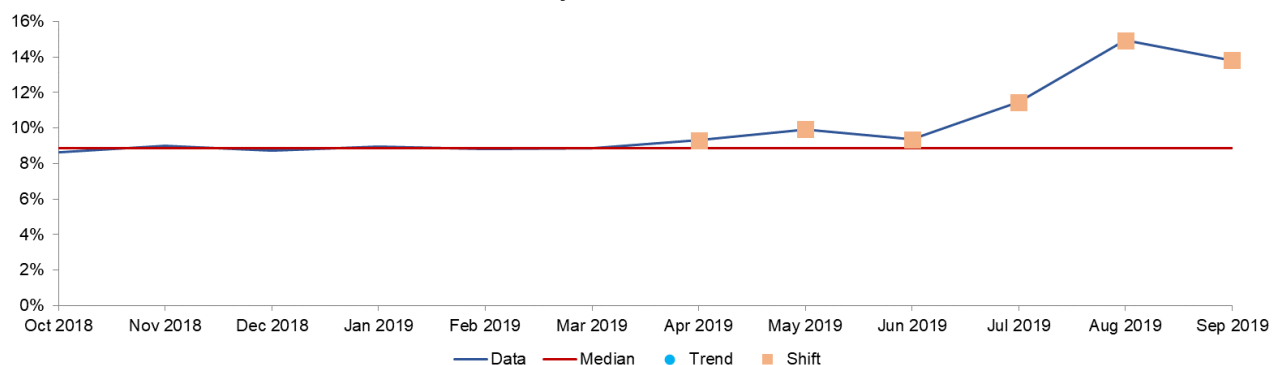
Surgery annual staffing metrics							
October 2018 to September 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual locum hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	1,241	9%	18%	3.7%			
Medical staff	318	10%	37%	0.9%	11,513 (2%)	1,521 (<1%)	0 (0%)

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

Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

Vacancy rates

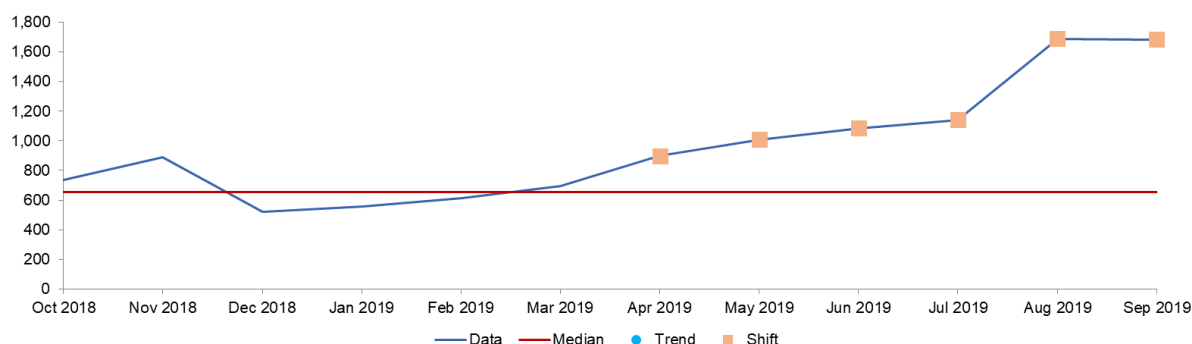
Vacancy rate - medical staff



Monthly vacancy rates over the last 12 months for medical staff show an upward shift from April 2019 to September 2019. This could be an indicator of change.

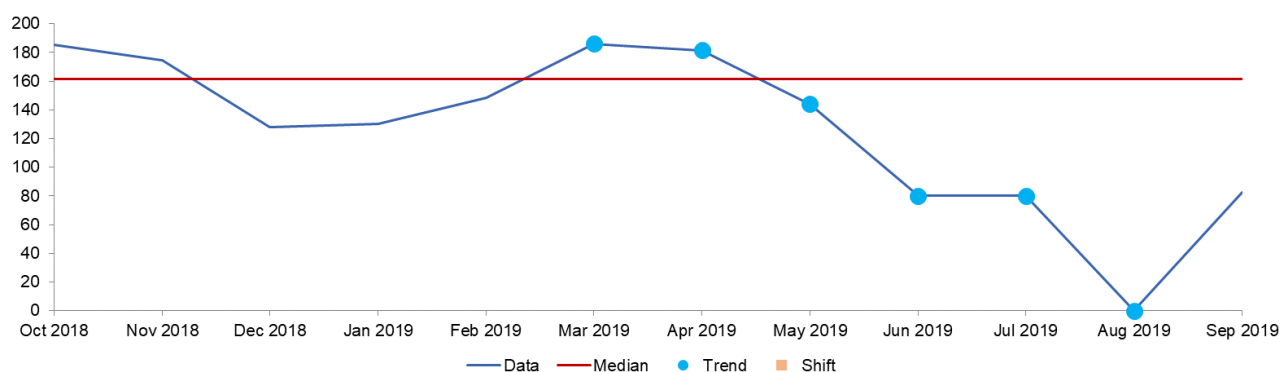
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Bank hours - medical staff



Monthly bank use over the last 12 months for medical staff show an upward shift from April 2019 to September 2019.

Locum hours- medical staff



Monthly locum use over the last 12 months for medical staff show a downward trend from March 2019 to August 2019. This could be an indicator of change.

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

Royal Hampshire County Hospital

The table below shows a summary of the medical staffing metrics in surgery at Royal Hampshire County Hospital compared to the trust's targets, where applicable:

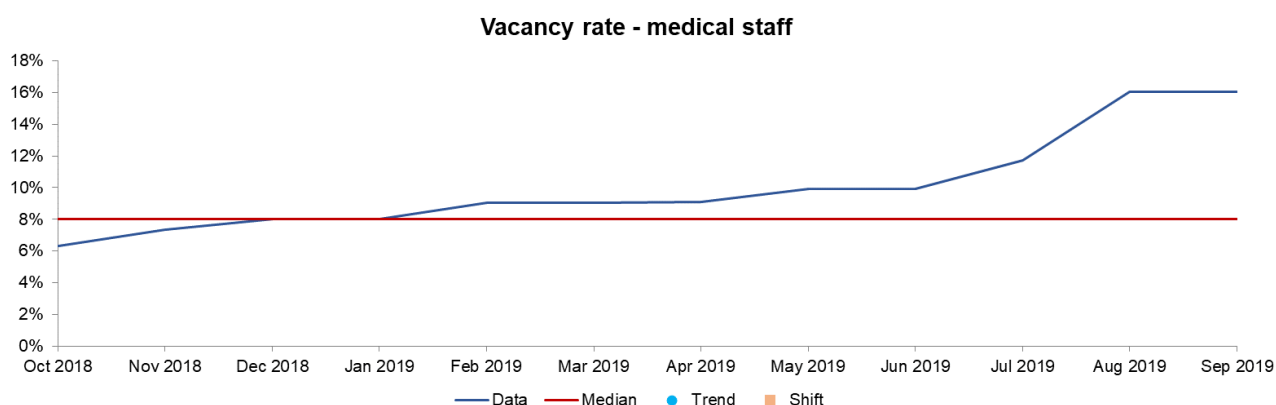
Surgery annual staffing metrics

Staff group	October to December 2019						
	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual locum hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	368	10%	17%	3.5%			
Medical staff	104	10%	34%	0.6%	1,527 (1%)	0 (0%)	0 (0%)

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

Medical staffing rates within surgery at Royal Hampshire County Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and locum use.

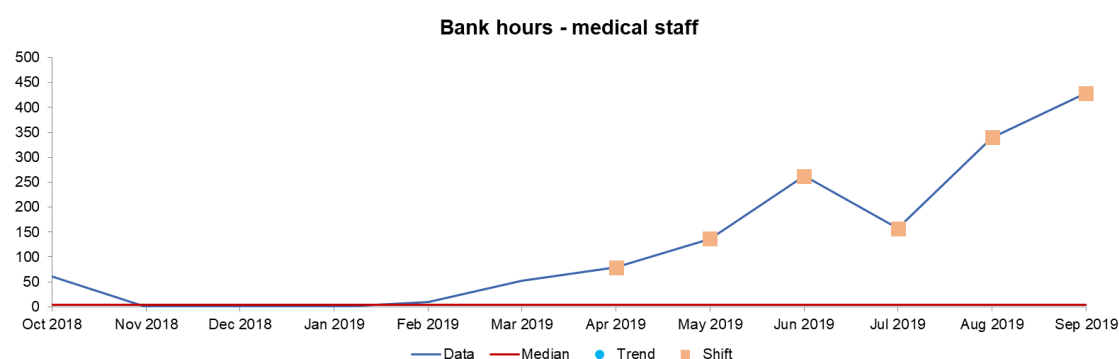
Vacancy rates



Monthly vacancy rates over the last 12 months for medical staff were not stable and may be subject to ongoing change. We spoke to leaders of the service who explained that doctors in training were included in the vacancy and turnover figures, who change yearly in August. This explained the variation.

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

Bank staff usage



Monthly bank use over the last 12 months for medical staff show an upward shift from April 2019 to September 2019. This could be an indicator of change.

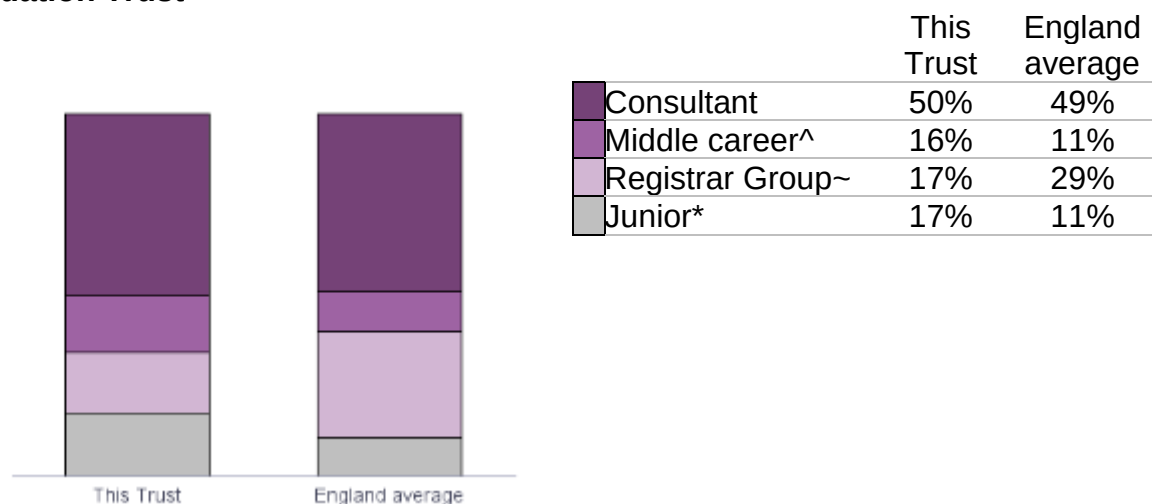
(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

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

Staffing skill mix for the whole-time equivalent staff working at Hampshire Hospitals NHS Foundation Trust



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

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

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

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

The service used a mixture of paper and electronic patient records. Patient notes were comprehensive, and all staff could access them easily. This was an improvement since our last inspection when they were inconsistent and not easily accessible. Paper records were kept securely in cabinets with key lock access which were locked during the inspection. This was also an improvement since our last inspection when patient records were not always stored securely.

We reviewed 16 sets of patient records and saw a good standard of record keeping. Staff had signed and dated all entries in line with General Medical Council standards and Nursing and Midwifery Council.

All the records we reviewed had patient care plans that showed all their care needs and were up-to-date. The majority of risk assessments we reviewed had been completed and reviewed and actions identified to reduce risks. This was an improvement since our last inspection when we found risk assessments not completed correctly.

Patients received continuity of care after discharge. Discharge information was sent automatically electronically to the patient's GP after discharge.

The service undertook patient record audits to check the standard of documentation within records. For example, data from July 2019 to December 2019 showed 100% compliance across all theatres and the treatment centre.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, there was a lack of pharmacy oversight, support and presence in wards and departments. Issues found at the previous inspection in relations to medicine management had been resolved.

Since our last inspection and because of the continued lack of pharmacy support, staff working in wards and departments had assumed responsibility of the management of medicines in their areas to mitigate risk. Clinical areas had developed their own processes for the safe management of medicines.

At the previous inspection we found issues with pharmacy support for staff working in wards and departments, this issue remained unchanged. Staff in wards and departments were responsible for ordering medicines, checking expiry dates and keeping stock levels. Staff told us that it was very rare for a pharmacist to visit departments and wards. Staff told us that there was a focus on ensuring medicines that patients needed on discharge were prioritised.

We spoke to the leadership team about the lack of pharmacy support, they explained it was due to several pharmacist vacancies within the trust and they were currently trying to recruit to the vacancies.

As clinical staff were responsible for ordering medicines, there was no oversight of the amount of medicines used. This did not provide assurance that medicines were not being diverted or misused.

We asked the trust to supply us with updated data on compliance with medicine management training. The trust explained that there were 31 different modules for doctors and nurses in relation to medicine training in addition to the generic training. Staff completed the module most relevant to their role. The trust deemed this to mean they were compliant with the medicine training most relevant to their role. For example, a specialist pain nurse would complete the patient controlled analgesia (pain relief) training. This was not captured in the data within the data in the mandatory training section of this report. More recent data supplied to us showed that 53% of nurses within surgery had completed the generic training. However, this data included new starters and health care assistants not required to undertake the training

From 1 October to 31 December 2019, a total of 114 medicine incidents were reported in the Surgical Services Division at the trust HHFT.

The majority of medication incidents were reported as no harm incidents (92%), with a further 8% accounting for low harm incidents (minimal harm caused).

The themes found were 26 omitted or delayed doses of medicines. Nine incidents related to discrepancies involving discharge medicines, 22 incidents related to controlled drugs, 21 incidents where the wrong dose of medicine was administered or prescribed and 16 incidents, where the wrong medication was administered.

The pharmacy department produced medicine safety bulletins to share themes of incidents and learning from incidents involving medicines.

A traffic light system had been introduced check medicines were within the manufacture's expiry date and safe to use. We saw all medicines had their expiry date on the box highlighted in red, amber or green. Red meant it was due to expire at the end of that month, amber in two months and green over three months. We saw this was consistently done when medicines were removed from the storage cupboard for use. This alerted staff to the manufacture's expiry date.

Staff stored and managed medicines and prescribing documents in line with the trust's policy. Medicines (including controlled drugs) were stored securely. Controlled drugs are medicines liable for misuse that are controlled under the Misuse of Drugs legislation. On wards and departments two qualified nurses checked controlled drugs weekly, this was in line with the trust's policy. In theatres controlled drugs were checked at the beginning and end of each operating list and once within a 24-hour period at weekends.

We reviewed controlled drug storage in theatres and on the surgical wards and saw documentation of daily and weekly checks with no gaps. We checked randomly selected controlled drugs and saw the quantity stored in the controlled drugs cupboard matched the quantity recorded in the controlled drugs book.

Theatres undertook monthly controlled drug audits which showed compliance had improved. Compliance ranged between 68% in September 2019 to 96% achieved in December 2019. We saw laminated signs on controlled drug cupboards with information on how to record correctly in the controlled drug register and what action to take if a discrepancy was found.

Six monthly controlled drug audits were undertaken on wards. We reviewed some of these audits which generally showed good compliance, all areas of non-compliance had actions. For example, entries crossed out by staff was discussed at ward meetings.

The service stored refrigerated medicines at the correct temperatures to remain effective. Staff checked and recorded fridge temperatures daily. This was an improvement since our last inspection when fridge temperatures were not checked daily. There was clear guidance on what action staff should take if temperatures were out-of-range. We saw staff acted when this occurred for example, resetting the fridge.

The service monitored the temperature in clinical rooms. This ensured medicines were stored in line with manufacturer's guidelines. This was an improvement since our last inspection when room temperatures were not monitored.

Ventilation in the clinical room on Kemp Welch ward had been improved since our last inspection, this meant the fridge no longer overheated. This was found at the last inspection and had now been addressed.

There were specific medicine boxes in wards and departments to deal with emergencies such as hypoglycaemia (low blood sugar) or anaphylaxis (extreme allergic reaction). When we checked these boxes, they contained medicines on the contents list and were in date.

Since our last inspection the trust had implemented mandatory medicine management training. However, compliance was poor only 50.5% of nursing staff had completed the training and 7.1% of doctors. Staff we spoke to told us that they had undertaken the training and had a good awareness of medicine management.

The service had developed processes to improve medicine safety in response to incidents involving medicines. Theatre staff explained to us about an incident when the medicine suxamethonium was given to a patient instead of fentanyl. Suxamethonium is a muscle relaxant medicine used to cause short-term paralysis (loss of the ability to move) as part of general

anaesthesia. Fentanyl is a strong pain killer. Staff showed us that suxamethonium was now in pre-filled syringes kept in each fridge in anaesthetic rooms in a labelled sealed plastic box. Staff explained how it was no longer drawn up as an emergency medicine with other emergency medicines so that it could not be given in error.

Another action from the same incident was that all muscle relaxants must have two labels on the syringe. This made it visually more obvious. We observed this was consistently undertaken.

Theatres had a standard operating procedure which said that all intravenous medicines must only be prepared when there was two people present to double check the process. We saw this was consistently undertaken in both Nightingale theatres and in the theatres within the treatment centre.

Theatres used a colour coded tray system for medicines, to act as a visual prompt for staff. Red trays contained emergency medicines, yellow trays contained local anaesthetic medicines and clear trays were for all other medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff explained that incidents were reported using an electronic reporting system. Staff gave us examples of incidents they had reported and confirmed they received feedback about the incident.

Staff received feedback from investigation of incidents and could describe learning and changes to practice following incidents. Examples given to us included all patients have a full tissue viability assessment before leaving theatres after an operation. This was in response to an incident when a patient had tissue damage after an operation. We saw recovery staff undertook the assessment and documented it within the patients records. This identified any tissue damage or pressure areas which may need treatment.

The service used a variety of methods to ensure staff received feedback about incidents. Information was emailed to staff and spoken about in daily huddles, meetings and handovers. Theatres had a noticeboard with recent incidents that had occurred and the learning from them. Incidents and learning from them was also discussed at monthly audit meetings in theatres. theatre team had the latest five incidents that had occurred in the department on a noticeboard and the learning from them was shared.

A Monday morning meeting led by the matron of theatres had recently started. We reviewed meeting minutes which showed learning from incidents was shared and what incidents had been reported. For example, the 9 December 2019 meeting minutes discussed incidents relating to containers filled with formalin that did not have the lids on properly which was a risk to staff. Formalin is a substance used to preserve tissues.

The trust supplied us with incident data for the surgery services across of three hospital from 1 October 2019 to 30 September 2019. During this period there were a total of 2548 incidents

reported. The top three themes were, implementation of care or ongoing care (35% of all incidents, accident that may result in personal injury (15%) and medicine incidents (11%).

There were 1795 incidents resulting in no harm, 717 incidents resulting in low harm. There were 19 incidents that resulted in moderate harm, 15 incidents resulting in severe harm and two incidents resulting in death.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where applicable. We reviewed three root cause analysis investigations. We saw evidence of thorough investigation and patient and family involvement. The investigations found the root causes of serious incidents and made recommendations for learning. Each root cause analysis report had an action plan, with clear timelines and accountability for the completion of actions to implement and share learning. Actions were categorised as immediate, to be completed within 48 hours and essential, to be completed in 30 days.

Monthly ward dashboards included the number and severity of incidents reported. This meant managers had oversight to monitor for any themes and trends and they were reviewed at governance meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Evidence from root cause analysis reports we reviewed showed the service applied the Duty of Candour correctly.

Never events

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

From December 2018 to November 2019, the trust reported no never events within surgery at Royal Hampshire County hospital.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2018 to November 2019. A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	11	55%
Pressure ulcer meeting SI criteria	3	15%
Surgical/invasive procedure incident meeting SI criteria	2	10%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	5%
Medication incident meeting SI criteria	1	5%

Sub-optimal care of the deteriorating patient meeting SI criteria	1	5%
VTE meeting SI criteria	1	5%
Total	20	100%

(Source: Strategic Executive Information System (STEIS))

Royal Hampshire County Hospital

In accordance with the Serious Incident Framework 2015, Royal Hampshire County Hospital reported six serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2018 to November 2019.

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

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	3	50%
Medication incident meeting SI criteria	1	17%
Pressure ulcer meeting SI criteria	1	17%
Surgical/invasive procedure incident meeting SI criteria	1	17%
Total	6	100%

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

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

Safety thermometer data was displayed on wards for staff and patients to see. Staff used the safety thermometer data to further improve services. For example, there was a focus on reducing falls and pressure ulcers safety thermometer data was used to monitor a reduction in these.

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

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

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

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

Total Pressure ulcers (35)



Total Falls (19)



Total CUTIs (6)



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

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

Staff had access to national guidance and had made improvements since our last inspection to ensure treatment was consistently based on national guidance and that staff followed this guidance.

In theatres, we observed the theatre team was following the World Health Organisation (WHO) Surgical Safety Checklist and 'five steps to safety' surgical approach. We observed that the fifth step (debrief) was undertaken, this was an improvement since our last inspection when it was not undertaken trust wide. We reviewed a variety of World Health Organisation Surgical Safety Checklist audits, although not all showed 100% compliance the majority showed good compliance.

Staff consistently carried out the on admission venous thromboembolism assessments and prescribed appropriate treatment, in line with National Institute for Health and Care Excellence (NICE) quality standard QS3. However, we reviewed 14 patient medicine charts and none of the charts showed patients had their risk reassessed within 24 hours of admission in line with the same guidance.

Staff followed up-to-date policies to plan and delivered high quality care according to best practice and national guidance. This included NICE and the Royal College of Surgeons guidelines. For example, we reviewed 16 patient records and saw all had physiological observations recorded at

the time of their admission or initial assessment. This was in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.

We saw patient information booklets told patients to shower or have a bath using soap, either the day before, or on the day of, surgery. This was in line with NICE guideline NG125: Surgical site infections: prevention and treatment.

The service audited staff compliance with trust policies and national guidance. This included monthly audits on the World Health Organisation Surgical Safety Checklist, national early warning tool, nutrition tool and pressure area care. Audits provided assurances of compliance and helped find areas for improvement.

Compliance with national guidelines and best practice was monitored and implemented by the trust's clinical effectiveness group. The purpose of this group was to oversee and seek assurance on the implementation of national and local guidelines and standards to ensure best practice across the trust. Each division was required to prepare and present a report to the group which highlighted compliance with best practice and national guidelines as well as areas of concern.

We saw staff in pre-assessment followed evidence-based protocols to assess patients' fitness for surgery. For example, NICE guideline NG45: Routine preoperative tests for elective surgery.

Patients undergoing joint replacements or revisions such as a knee replacement were offered an enhanced recovery programme. Patients attended "joint school" in advance of their operation, to prepare them for their surgery and what to expect after surgery. Enhanced recovery programmes have been shown by the NHS Institute for Innovation and Improvement, to help patients recover more quickly after surgery.

Staff accessed policies and standard operating procedures electronically through the trust intranet and knew how to do this. Policies we reviewed had version numbers and were within the review date. Paper copies were also available in some areas.

The service took part in a variety of relevant national audits to measure the effectiveness of the care and treatment provided and used audit findings to improve patient care and outcomes. For example in the National Hip Fracture audit, a comprehensive action plan had delivered better outcomes for patients.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. However, audit findings varied on assessment of nutrition.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Feedback from patients about the food was positive.

The trust provided menus to meet different nutritional and cultural needs, including diabetics, vegetarian, low fibre, low fat, gluten free and halal. Patients ordered meals via an electronic system which could be programmed individually for example, to only show vegetarian options.

The trust took part in Patient-led assessments of care environment (PLACE). These were annual assessments involving local people who went into hospitals to assess the quality and provision of

food. In the November 2019 PLACE survey assessors ate nine different foods on Wainwright ward and all scored good for taste, texture and temperature. In the fourteen different areas assessed for general food assessment, service and presentation Wainwright ward scored positively in 12 areas.

Staff fully and accurately completed patient's fluid and nutrition charts where needed. We saw completed fluid charts within patients records. Patients receiving total parenteral nutrition, had an up-to-date, completed chart to monitor the feed, which was signed and dated by staff. Total parenteral nutrition is a special feeding technique to provide nutrients through a drip into a vein for patients unable to take food or fluids by mouth.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The service used the Malnutrition Universal Screening Tool a validated nutritional screening tool. It is a simple five step tool designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk. Patient records we reviewed showed these were completed correctly and fully. This was an improvement since our last inspection when weights and heights were missing. However, audit results showed varied compliance in the assessment of nutrition. The trust colour coded compliance with; green achieved the standard, yellow partially achieved and red not achieved. Between October 2019 and January 2020, Wainwright ward achieved two green, one red and one yellow scores, St Cross ward achieved two yellow and one red and Bartlett ward achieved three green and one red.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. Staff knew when and how to refer patients to specialist staff if required. A staff member gave us an example of when they had referred a patient to the dieticians and they were reviewed by them the following day.

Kemp Welch ward had a noticeboard which displayed every bed number and indicated if they were nil by mouth or needed support with eating. Staff said this was updated every day before meal times and every time someone had a dietary change. This ensured staff knew who was nil by mouth or required support with eating.

On St Cross ward we saw there was a nutrition board with useful information for patients and visitors. It included information on healthy eating and why it was important, why patients had to be nil by mouth before their operation and for how long and information on high calories and high fortified foods.

Pain relief

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

Staff assessed patient's pain using recognised tools and gave pain relief in line with individual needs and best practice. Staff considered patients who were unable to verbally communicate about pain and ensured any visual signs were monitored and appropriate pain relief provided.

We reviewed records and saw regular pain assessments recorded on the mobile software information system. We saw pain was reassessed after pain relief medicines had been given to check the effectiveness. Staff prescribed, administered and recorded pain relief accurately.

The service used the Abbey Pain Scale tool to aid in the assessment of pain in patients who were unable to articulate their needs. For example, patients with communication difficulties or patients

living with dementia. The trust undertook audits to provide assurance the needs of patients living with dementia were met. From October 2019 to December 2019 across the surgical wards 79% of patients living with dementia had a completed Abbey Pain Scale tool.

The service had appropriate safety protocols and equipment for patient-controlled analgesia and epidurals. An epidural is an injection in the back to provide patient pain relief in parts of their body. The service prescribed medicines to prevent nausea and vomiting.

There was acute pain service team that provided support and advice for managing pain in patients after surgery. The team was available Monday to Friday, from 9am to 5pm. Outside these hours, staff could access support from the on-call anaesthetist. The team visited every ward daily to review patients who may need specialist input from the pain team. Ward staff were very positive about the level of support and advice offered by the pain team.

Patient outcomes

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

Trust level

From June 2018 to May 2019, patients at the trust had a similar to expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a similar to expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions – Trust Level



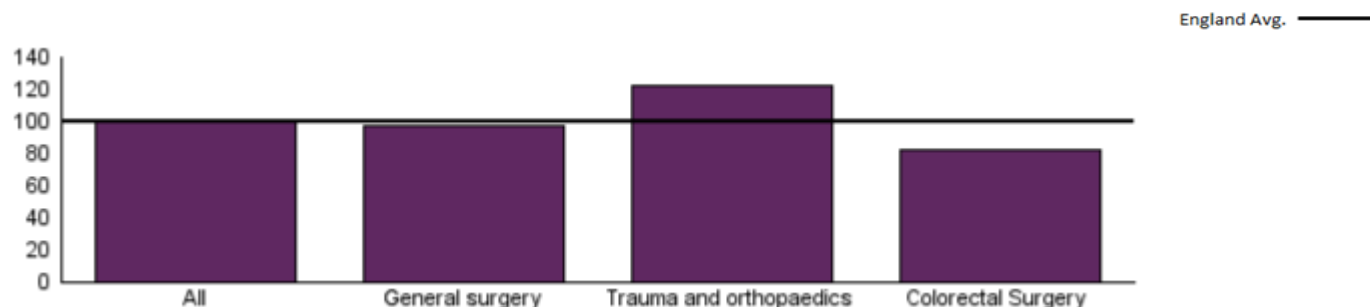
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count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

Patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Colorectal surgery patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level



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

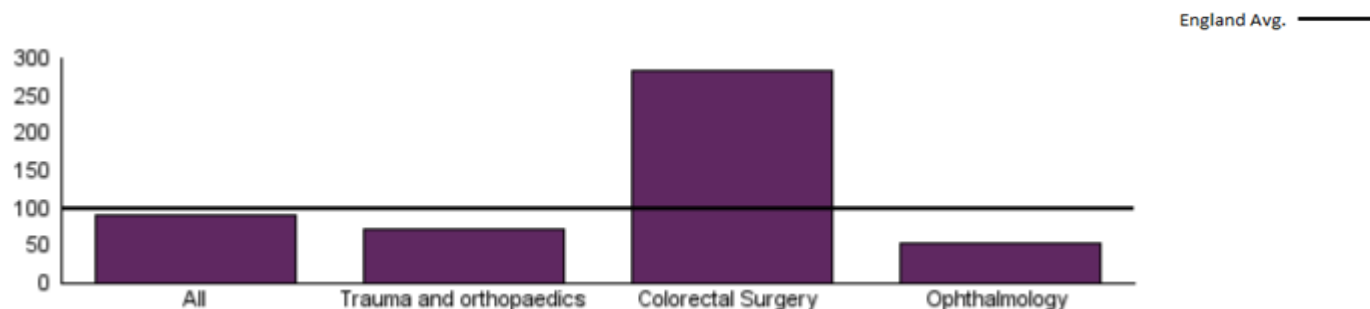
(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2018 - 31/05/2019))

Royal Hampshire County Hospital

From June 2018 to May 2019, patients at Royal Hampshire County Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Trauma and orthopaedics patients at Royal Hampshire County Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at Royal Hampshire County Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Ophthalmology patients at Royal Hampshire County Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Royal Hampshire County Hospital



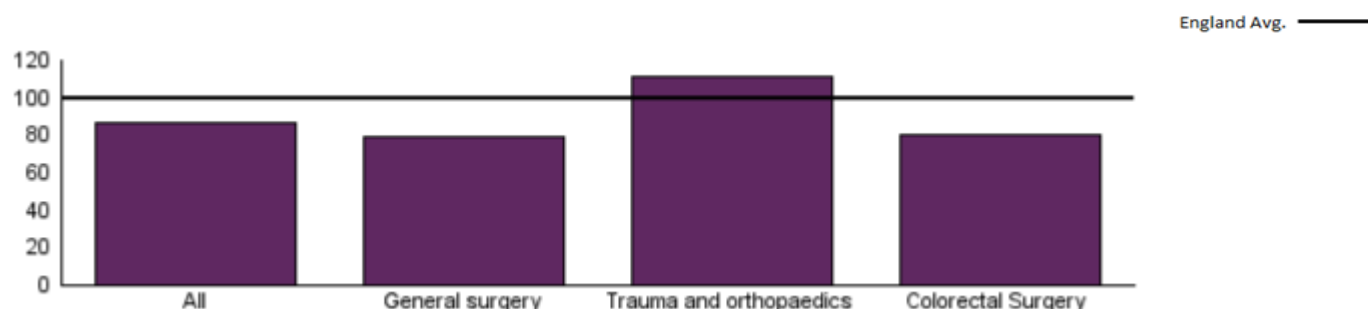
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of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

Patients at Royal Hampshire County Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at Royal Hampshire County Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Royal Hampshire County Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Colorectal surgery patients at Royal Hampshire County Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - Royal Hampshire County Hospital



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

(Source: Hospital Episode Statistics)

National Hip Fracture Database

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

Metrics (Audit indicators)	Hospital performance	Comparison to other Trusts	Met national standard?
Case ascertainment (Proportion of eligible cases included in the audit)	113.8%	Better	Met
Crude proportion of patients having surgery on the day or day after admission (It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)	89.5%	Better	Met
Crude peri-operative medical assessment rate (NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)	88.3%	Worse	Did not meet
Crude proportion of patients documented as not developing a pressure ulcer (Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's admission); this measures an organisation's	91.9%	Worse	Did not meet

ability to report 'documented as no pressure ulcer' for a patient			
Crude overall hospital length of stay (A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)	23.0 days	Worse	No current standard
Risk-adjusted 30-day mortality rate (Adjusted scores take into account the differences in the case-mix of patients treated)	8.3%	Within expected range	No current standard

(Source: National Hip Fracture Database)

The trust was notified by the National Hip Database of an "alert" of an increased crude 30 day mortality at Royal Hampshire County Hospital in the 2018 audit. We saw the hospital had investigated this thoroughly and undergone an external review and developed an action plan to address the issue. The hospital had taken several actions to address this issue, these included:

- Increased nursing staff on trauma wards
- Increased ortho-geriatric input
- Early identification of frail, high risk patients from presentation throughout their patient journey
- Increase in intra-operative consultant level surgeons and anaesthetists
- Increase utilisation of critical care to monitor and treat higher risk patients

The service undertook local audits to monitor 30-day crude mortality for fracture neck-of-femur patients (broken hip). Data collected and submitted to the National Hip Database in response to the "alert" showed, between September 2018 and July 2019 221 patients were admitted to the hospital with a fracture neck-of-femur of these four patients died. This data over the eleven months meant a reduction of crude 30-day mortality to 1.8% for fracture neck-of-femur patients. This showed the hospital had responded to results of an audit and it was used to improve care and treatment and this improvement was checked and monitored.

Please note as of December 2019, as the result of the orthopaedic transformation project, patients with a fracture neck-of-femur were no longer admitted to Royal Hampshire County Hospital.

Bowel Cancer Audit

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the 2018 National Bowel Cancer Audit.

Outcomes for patients in the 2018 Bowel Cancer Audit were consistent or better than when compared to other trusts.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Met national standard?
Case ascertainment (Proportion of eligible cases included in the audit)	77.9%	Fair	Fair (50%-80%)
Risk-adjusted post-operative	54.1%	Better than	No current

length of stay >5 days after major resection <i>(A prolonged length of stay can pose risks to patients)</i>		national aggregate	standard
Risk-adjusted 90-day post-operative mortality rate <i>(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)</i>	4.1%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate <i>(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</i>	15.4%	Within expected range	No current standard
Risk-adjusted 30-day unplanned readmission rate <i>(A potential risk for early/inappropriate discharge is the need for unplanned readmission)</i>	8.1%	Within expected range	No current standard
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection <i>(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases, it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)</i>	39.7%	Within expected range	No current standard

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not take part in this audit.

(Source: National Vascular Registry)

National Oesophagus-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

Outcomes for patients in the 2018 National Oesophagus-gastric Cancer Audit were consistent or better than when compared to other trusts.

The table below summarises Hampshire Hospitals NHS Foundation Trust's performance in the 2018 National Oesophagus-gastric Cancer Audit.

Metrics <i>(Audit measures)</i>	Trust performance	Comparison to other Trusts	Met national standard?
Trust-level metrics <i>(Measures of hospital performance in the treatment of oesophagus-gastric (food pipe and</i>			

<i>stomach) cancer)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	71 to 80%	Similar	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission <i>(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</i>	0.8%	Better	No current standard
Risk adjusted 90-day post-operative mortality rate <i>(Proportion of patients who die within 90 days of their operation)</i>	Not eligible	N/A	No current standard
Cancer Alliance level metrics <i>(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophagus-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)</i>			
Crude proportion of patients treated with curative intent in the Cancer Alliance <i>(Proportion of patients receiving treatment intended to cure their cancer)</i>	42.6%	Better	No current standard

(Source: National Oesophagus-Gastric Cancer Audit)

National Emergency Laparotomy Audit

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the December 16 to November 17 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 55 of patients achieving the standard), amber (between 55% and 85% of patients achieving the standard) and green (more than 85% of patients achieved the standard).

Only one of the standards was not met.

Metrics <i>(Audit measures)</i>	Hospital performance	Audit's Rating	Met national standard?
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	100%	Green	Met
Crude proportion of cases with pre-operative documentation of risk of death <i>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</i>	82%	Amber	Did not meet
Crude proportion of cases with access to theatres within clinically appropriate time frames <i>(Proportion of patients who were operated on within recommended times)</i>	97%	Green	Met
Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in	96%	Green	Met

theatre (Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)			
Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to surgery post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)	100%	Green	Met
Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)	9%	Within expected range	No current standard

(Source: National Emergency Laparotomy Audit)

The service undertook a local Emergency Laparotomy audit and reports to monitor performance and identify areas where they were performing well, and areas identified as needing improvement. The service had a lead for the audit and developed an action plan to address areas where performance was not meeting the standard. Progress with the action plan and performance was shared regularly in general surgery governance meetings. We reviewed the latest report (December 2019) which had three actions, all of which had a nominated individual, time deadlines and the priority of the action.

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises Hampshire hospitals NHS Foundation Trust's performance in the 2018 National Ophthalmology Database Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Met national standard?
Trust-level metrics (Measures of hospital performance in the treatment of cataracts)			
Case ascertainment (Proportion of eligible cases included in the audit)	74.8%	N/A	No current standard
Risk-adjusted posterior capsule rupture rate (Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.)	0.6%	Positive outlier	No current standard
Risk adjusted visual acuity loss (The most important outcome following cataract surgery is the clarity of vision)	0.3%	Positive outlier	No current standard

(Source: National Ophthalmology Database Audit)

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

Royal Hampshire County Hospital

The table below summarises Royal Hampshire County Hospital's performance in the 2018 National Joint Registry.

	Metrics (Audit measures)	Hospital performance	Comparison to other hospitals	Met national standard?
Trust-level	Case ascertainment (hips, knees, ankles and elbows) <i>(Proportion of eligible cases within the trust that were submitted to the audit)</i>	81.9%	Similar	Did not meet
	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) <i>(Patient details help 'track and trace' prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)</i>	87.0%	Similar	Did not meet
Hospital level: Hips	Risk-adjusted 5-year revision ratio (for hips excluding tumours and neck of femur fracture) <i>(Proportion of patients who need their hip replacement 're-doing')</i>	0.9	Within expected range	Met
	Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) <i>(Proportion of patients who die within 90 days of their operation)</i>	1.0	Within expected range	Met
Hospital level: Knees	Risk-adjusted 5-year revision ratio (for knees excluding tumours) <i>(Proportion of patients who need their knee replacement 're-doing')</i>	1.0	Within expected range	Met
	Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) <i>(Proportion of patients who die within 90 days of their operation)</i>	1.0	Within expected range	Met

(Source: National Joint Registry)

The service monitored performance in the National Joint Registry Audit to identify areas for improvement or good performance. Regular National Joint Registry review meetings were held. At these meetings each individual consultant presented their own outcome data, in order to benchmark and highlight any areas of concern and where improvements could be made. We reviewed the meeting minutes from October 2019 which showed ideas for improvements to meet the standards and actions to take forward.

National Prostate Cancer Audit

The table below summarises Hampshire *Hospitals NHS Foundation Trust's* performance in the 2018 National Prostate Cancer Audit.

Metrics (Audit measures)	Hospital performance	Comparison to other trusts	Met national standard?
Men with complete information to determine disease status (This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)	89.8%	N/A	Did not meet
Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy (A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)	No data available	N/A	No current standard
Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy (Complications following surgery may reflect the quality of surgical care)	No data available	N/A	No current standard
Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy (External beam radiotherapy uses high-energy beams to destroy cancer cells)	22.1%	Within expected range	No current standard

(Source: National Prostate Cancer Audit)

Adult cardiac surgery

The trust did not take part in this audit.

(Source: National Cardiac Audit Programme)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements

- Knee replacements

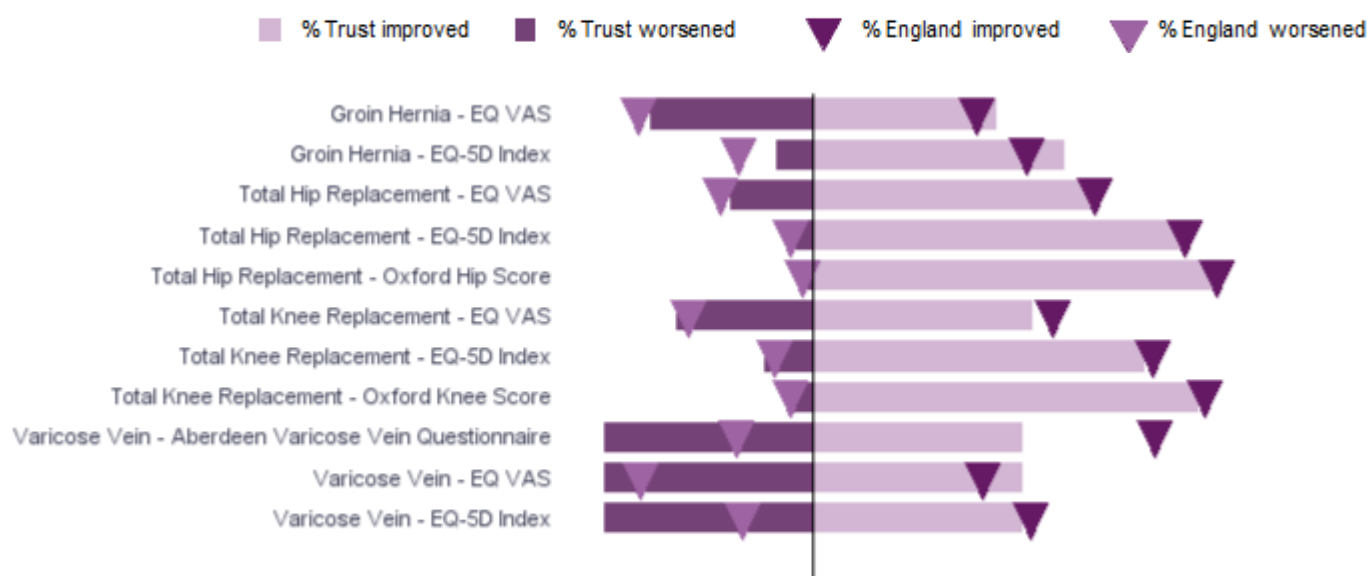
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.



In 2016/17 performance on groin hernias was better than the England average for both EQ VAS and EQ-5D Index indicators.

In 2016/17, performance on varicose veins, was worse than the England average for the Aberdeen varicose vein questionnaire, EQ VAS and EQ-5D index indicators.

For hip replacements, performance was about the same as the England average for EQ VAS, EQ-5D index and the Oxford hip score indicators.

For Knee replacements performance was better than the England average for the Oxford knee score, EQ VAS and EQ-5D index indicators.

(Source: NHS Digital)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits.

Managers and staff investigated audit outliers, implemented local changes to improve care and monitored the improvement over time. For example, in the National Hip Fracture Data audit.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers made sure staff received any specialist training for their role. For example, theatre staff undertook specialist training on specialist techniques such as cell salvage. Cell salvage is a way of collecting a patient's own blood lost during or after surgery. This blood can then be recycled by infusing it back to the same patient.

Practice development facilitators supported the learning and development needs of staff. In theatres there was a monthly audit afternoon, the professional development leads created the agenda of these meeting specific to the learning needs of theatre staff.

We saw in theatres that the roles and responsibilities for different roles were displayed. This ensured staff were aware of the different roles, responsibilities and scope of practice.

We spoke with junior doctors who told us they had structured protected teaching sessions at least once a week. They were positive about their training experience and support from peers. The junior doctors we spoke with told us they had a dedicate clinical supervisor who supported their learning. They told us they had opportunities to work in specialist areas such as theatres.

The trust had a chief registrar who was a senior doctor within orthopaedics. The chief registrar programme is facilitated by the Royal College of Physicians and is a work-based leadership programme for senior doctors in training. The role provides protected time for doctors in training to practice leadership and quality improvement while remaining in clinical practice. The chief registrar provides a bridge between senior clinical leaders, managers and trainee doctors. They collaborate across teams to deliver better outcomes and address local challenges. We were given examples of this during our inspection, staff were positive about the role.

The serviced supported staff development into other roles and gave them the opportunities to do so. In theatres we spoke to staff who were health care assistants and had undergone additional training to become advanced theatre practitioners. Another example of this was in ward areas where health care assistants had undergone additional training to become clinical nurse assistants, staff described these as a "god send".

We reviewed competency assessments for a variety of different roles, which showed staff completed a competency package relevant to their role. For example, in theatres there were different competencies for health care assistants, advanced theatre practitioners, scrub practitioners, anaesthetic practitioners and recovery staff. We also saw certificates providing evidence of continuing professional development.

Health care assistants completed competencies in key skills such as using the national early warning score tool, simple wound care, catheter care and recording fluid balance.

Managers gave all new staff a full induction tailored to their role before they started work. We saw examples of completed inductions which outlined key information and signposted staff to other resources to support their induction programme.

The appraisal system had recently changed to an electronic system, the same system used for mandatory training. Staff were positive about the new appraisal system. One member of staff told us they liked it because there was the choice of not having to develop further or have career progression aspiration if they were happy with their current role. The system included a section on assessing the staff member's wellbeing and what managers could do to support their wellbeing.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

Trust level

As at September 2019, 89.0% of required staff in surgery received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Estates and ancillary	16	17	94.1%	90%	Yes
Allied health professionals	24	26	92.3%	90%	Yes
Additional clinical services	211	229	92.1%	90%	Yes
Administrative and clerical	188	209	90.0%	90%	Yes
Nursing and midwifery registered	372	421	88.4%	90%	No
Medical and dental	157	181	86.7%	90%	No
Add prof scientific and technical	28	36	77.8%	90%	No
Total	996	1,119	89.0%	90%	No

Royal Hampshire County Hospital

As at September 2019, 86.9% of required staff in surgery Royal Hampshire County Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Administrative and clerical	28	28	100.0%	90%	Yes
Estates and ancillary	10	10	100.0%	90%	Yes
Nursing and midwifery registered	106	120	88.3%	90%	No
Medical and dental	47	54	87.0%	90%	No
Additional clinical services	65	78	83.3%	90%	No
Allied health professionals	5	6	83.3%	90%	No
Add prof scientific and technical	18	25	72.0%	90%	No
Total	279	321	86.9%	90%	No

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

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients.

The hospital opened a same day Emergency care unit next to the emergency department in October 2019. The unit provided support to the emergency department by treating emergency surgical patients that would normally be treated in the emergency department. The same day emergency care unit had two pathways for patients those attending with a medical problem and those attending with a surgical programme. Staff told us there was a multidisciplinary approach to managing patients in this area, collaborating with staff in the emergency department, local GP's, outpatients and surgeons.

Staff in the pre-assessment unit told us of the close working relationship they had with specialty nurses who supported the pre-assessment process to ensure patients were optimised for surgery.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary meeting during our inspection on Kemp Welch ward. It was attended by nurses, doctors and a physiotherapist. All staff interacted well together and discussed any issues with patients such as blockers to discharging patients.

The hospital had recently introduced a medical outlier team which was multidisciplinary. They worked alongside the staff on the surgical wards to ensure medical outliers (medical patients on non-medical ward) there had timely reviews and treatment.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff reported it was easy to access support and guidance if required.

Surgical services were available seven days a week at the hospital. Elective surgery was available Monday to Friday and could be available at the weekend if needed.

Consultant surgical and anaesthetic cover was available 24 hours a day seven days a week, they were either in the hospital or on call.

At weekdays a surgical consultant was present on site between 8am to 6pm and on call after this time. At the weekends a surgical consultant would undertake the 8am ward rounds, if there were no operations planned for the day they would be on call thereafter.

The critical care outreach team was available seven days a week, between 8am and 8pm to access and provide support for deteriorating patients on the surgical wards.

Physiotherapy services and occupational therapists were available seven days a week. However, at weekends due to reduced staffing levels they prioritised patients with the greatest clinical need.

Patient outpatient pharmacy services were available five days a week from 9am to 5pm. At the weekends the main hospital pharmacy was open 9:15am to 1pm on Saturday and Sunday to support and weekend discharges. There was an on-call pharmacist service outside of these hours.

The hospital chaplaincy team provided spiritual and pastoral care, seven days a week, 24hours a day, to patients, visitors and staff. The chapel was open 24hours a day.

There was a staffed emergency theatre, which was available twenty-four hours a day seven days a week for urgent operations. There was an additional theatre team on-call from home between 9pm and 8am seven days a week if another theatre was required for emergency operations.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, in pre-assessment patients were advised of the benefits of giving up smoking prior to their operation.

The service had relevant information promoting healthy lifestyles and support on the wards and departments. We saw a variety of information promoting a healthy lifestyle and diet in the pre-assessment unit. There were leaflets and posters displayed in the surgical wards including information on alcohol awareness and how to stop smoking.

The service promoted the PJ paralysis initiative. This was an initiative to get patients up out of bed and dressed every day. Research has shown that having patients dressed in their own clothes whilst in hospital reduces fall, improves patient experience and reduces length of stay.

Depending on the issue, patients would be signposted to relevant organisations to their GPs or support groups.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients

who lacked capacity to make their own decisions or were experiencing mental ill health. Not all staff had undertaken Mental Capacity Act training. However, staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983 and the Mental Capacity Act 2005. However, not all staff had received Mental Capacity Act training

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. This was an improvement from our last inspection when we were not assured that staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to give us examples when they discussed patients with senior staff and the doctors in charge of their care, when they were not sure a patient had capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We reviewed nine consent forms and found all were legible, and had documented the risks and benefits of surgery, in line with General Medical Council guidance.

The service undertook a variety of audits on the completion of consent forms. This provided assurance that they were legible, and had documented the risks and benefits of surgery, and were completed in line with General Medical Council guidance. We reviewed a hernia consent audit undertaken, this showed 100% of patients had the side documented, the risk of bleeding documented, the risk of infection documented, and the risk of reoccurrence documented.

We observed staff always verbally sought consent from patients before examination or treatment and this was documented within the patient records.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions

The hospital used two separate forms to record consent for a procedure or operation, one form included the intended procedure, risks, benefits, signature and name of the consenting doctor, the patient's signature was on another form. This meant there was a risk one part could be misplaced. We talked to one of the consultant surgeons about this who explained the hospital was in the process of changing over to a single sheet consent form and they were using up the supplies of the other forms.

Staff had a good understanding of Deprivation of Liberty Safeguards orders and how and when they should be completed and could give us examples of when they had been completed. Staff knew that a mental capacity assessment needed to be completed prior to completion of a Deprivation of Liberty Safeguards order. During our inspection, there were no patients on the surgical wards with a Deprivation of Liberty Safeguards order.

The trust used Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) in line with national guidance. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. We saw these had been completed in patient records we reviewed.

Mental Capacity Act and Deprivation of Liberty training completion

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	333	459	73%	90%	No

In surgery the target was not met for MCA/DoLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training modules from April to September 2019 at trust level for medical staff in surgery is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	173	290	59.7%	90%	No

In surgery the target was not met for MCA/DoLS training modules for which medical staff were eligible.

Royal Hampshire County Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training modules from April to September 2019 for qualified nursing staff in surgery at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	135	176	76.7%	90%	No

In surgery the target was not met for MCA/DoLS training modules for which qualified nursing staff at Royal Hampshire County Hospital were eligible.

A breakdown of compliance for MCA/DoLS training modules from April to September 2019 for medical staff in surgery at Royal Hampshire County Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	76	123	61.8%	90%	No

In surgery the target was not met MCA/DoLS training modules for which medical staff at Royal Hampshire County Hospital were eligible.

More recent data supplied to us by the trust showed Mental Capacity Act training compliance amongst doctors had improved to 70%.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff took time to interact with patients and those close to them in a respectful, caring and considerate way. For example, we observed a patient walking along the corridor with their family who was very unsteady on their feet, the family were trying to persuade them to get in the wheelchair, but they refused. We saw a member of recovery staff ask the family what the patient's name was, so they could address them. The staff member said to the patient "come on let's get you in this chair, it's a long walk down the corridor and its chilly", the patient then got into the chair and smiled at the member of staff.

Patients said staff treated them well and with kindness. Comments from patients included "Staff are amazing and great under time pressure and "I have received brilliant care". We also saw positive feedback in thank you cards from patients and relatives displayed on the wards and theatres.

There were white boards, which were located in busy corridors on the surgical wards, these displayed patient's full names and their location on the ward, this was consistent with our findings during the last inspection. However, since our last inspection the service staff sought the patient's consent to display their name on these boards and there was a column on the board which was ticked if the patient had given their consent. We observed this was consistently undertaken. Each patient was also given an information leaflet explaining they had the choice not to have their name displayed. We saw staff respected patient's wishes to have their name displayed on the white boards. For example, one patient only wanted their first name written on the board and we saw this wish was followed.

Staff followed policy to keep patient care and treatment confidential. Staff spoke in a lowered voice when discussing personal or confidential information with patients.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs or dementia. For example, we observed a multidisciplinary meeting. The patients on the ward living with dementia or had confusion or a phobia were discussed and the support they needed.

Staff supported patients who became distressed in an open environment and helped them keep their privacy and dignity. Vulnerable, confused or patients living with dementia were placed near the staff station on wards to allow for closer supervision and to ensure their dignity was maintained.

Staff respected patients' privacy and dignity. We saw in the treatment centre a patient did not have a dressing gown, so staff gave them another hospital gown to ensure they weren't exposed when they walked along the corridor. In theatres, staff-maintained patients' dignity by keeping them covered and not opening the doors in theatres until the patient was covered.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Specialist nurses such as breast care nurses gave emotional support to patients prior to their operation, during their admission and after discharge.

Staff were discreet and responsive when caring for patients and maintaining their dignity and respect. For example, we saw a patient walking on the ward who was slightly exposed at the back, we observed a nurse walked directly behind them to maintain their dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff signposted patients and relatives to organisations and groups within the hospital who could provide support.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff in theatres reassured and comforted patients before surgery and afterwards in recovery. We observed staff in recovery explaining to patients that their operation was finished, where they were and asking if they wanted sips of water. Staff in theatres considered the language they used when communicating with patients so not to cause alarm. For example, if patients were having a general anaesthetic as they were going to sleep staff asked them if they were warm enough. This assessed if they still responded to voice without causing alarm for example asking if they were asleep yet.

The chaplaincy team were available 24 hours a day, seven days a week to provide spiritual and emotional support for patients and relatives of all faiths, including those with no faith.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw a patient was distressed as they had been assessed as having a high risk of developing a venous thromboembolism. We observed a nurse took the time to explain to the patient why this was and the treatment plan to minimise the risk of developing a venous thromboembolism.

In pre-assessment there was information about the process and what patients could expect to happen. There were leaflets and information boards on what different tests and investigations may be required.

The service actively involved patients' relatives as partners in their care. Patient records we reviewed showed family involvement in discussions about care where applicable.

The trust's dementia team provided support for patients, relatives and carers of patients with dementia who have been admitted to one of our hospitals. The team were available Monday to Friday between 7am and 7pm. Relatives and carers could arrange a meeting with one of the team or simply have a chat about their loved one.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make advanced decisions about their care. We observed and multidisciplinary meeting where discharge arrangements were being made for a patient at the end of their life who wished to return home to be with their family.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Matrons invited previous patients and their families to return to the hospital for a coffee and a chat with the matron for that area. This allowed them to give feedback to the matron on the care and treatment they received and identify areas where improvements could be made.

Staff supported patients to make informed decisions about their care. For example, we observed an anaesthetist discussing the different types of anaesthetic options available to them. Patients were given the opportunity to ask any questions during conversations with staff.

Patients and their families could give feedback about the care they received in a variety of different ways. They could visit the trust's website, give feedback directly to the ward manager or matron, telephone the trust's customer care team or complete the Friends and Family Test Survey asking you if they would recommend the service to family or friends should they need care or treatment. In addition, anyone could become a member of the Foundation trust and they received regular newsletters and invitations to events.

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. For example, patients in theatres awaiting surgery provided feedback that staff were very noisy in this area. Since this, posters had been put up reminding staff to keep noise to a minimum in this area and the patient feedback had been shared with staff.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service provided a diverse range of elective and emergency surgery to meet the needs of the local population. Surgical services covered general surgery, urology, ear nose and throat, anaesthetics and elective orthopaedics.

There was provision for a dedicated emergency surgical theatre list every afternoon starting at 1.30pm and finishing at 5.30pm. However, this was only partially compliant with the Confidential Enquiry into Peri Operative Death recommendations, which requires these 24hours per day. We asked staff if they thought this was enough provision for patients requiring emergency surgery and they thought it was and didn't see it as a risk. If the need arose, emergency patients could be fitted in at the start or during current surgical lists.

The service worked with others in the wider system and local organisations to plan care. Following engagement with patients, staff and partner organisations, the trust were testing changes to the existing configuration of trauma and orthopaedic services across the hospitals in Basingstoke and Winchester, to understand the potential impact of centralising some of their trauma and orthopaedic services. The changes meant all patients who required an emergency inpatient stay or surgery on broken bones were admitted to Basingstoke and North Hampshire Hospital. Only patients undergoing elective orthopaedic procedures were admitted to Royal Hampshire County hospital.

The trust planned and organised services, so they met the changing needs of the local population. Winchester hospice was currently being built at Royal Hampshire County hospital, it was due to open in 2021. This would provide specialist palliative care at the hospice and at home helping patients to live as well as possible.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. From April to September 2019 the service reported one mixed sex breach. A mixed sex breach is when male and female patients share the same bay.

Facilities and premises were appropriate for the services being delivered. Due to the reconfiguration of trauma and orthopaedic services some ward areas had been refurbished and adopted to meet the service provided. For example, the surgical assessment unit on St Cross ward had been adapted to accommodate day case patients.

Ward areas and theatre were organised to accommodate patients and their relatives or carers. Waiting areas were suitable for their purpose, and we did not see any overcrowding. Signage was adequate to direct patients to the appropriate area.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access the hospital learning disabilities and dementia teams Monday to Friday between 7am and 7pm.

In December 2019, a same day emergency care unit opened near the emergency department. The purpose of this unit was to relieve pressure placed on the emergency department by surgical emergencies. More information about this service can be found in the access and flow section of the report.

St Cross ward was the dedicated elective orthopaedic ward, this was an infection prevention and control measure ensuring emergency and elective patients were not mixed. It also meant all the specialist elective orthopaedic teams were located in one place.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had a dementia team and a learning disability team, staff were extremely positive about the support and advice they offered. They had staff and equipment that could support the needs of patients living with dementia or patients who had a learning disability. They supported activities that patients could undertake such as lunch in the hospital café. Each ward had dedicated dementia and learning disability leads who had received additional training and had strong links with the trust's teams.

A team of trained volunteers supported patients with additional needs on wards. For example, there were trained volunteers to help with feeding patients, we saw these volunteers during our inspection.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. This allowed staff to learn about and meet patients' individual needs and preferences.

The service used 'sunflower' symbol above patients bed spaces as a discrete means of identifying patients living with dementia for additional support.

Patients with learning disabilities were invited to visit the ward before their procedure to familiarise themselves with the staff and environment. The learning disability team would meet the patient at pre-assessment and support them throughout their patient journey. We were given an example of when a patient visited three times before their operation to ensure they were ready for the operation and their needs were met.

Staff met the communication needs of patients with a disability or sensory loss. They had access to communication aids to help patients become partners in their care and treatment. Wards and departments had resource boxes which contained communication aids. For example, an information booklet for staff on how to communicate better with patients who had difficulty communication or were non-verbal. Within the booklets were basic British Sign Language signs and pictures a diagrams of different body parts and symptoms such as a headache or stomach ache.

We were told that patients living with dementia could be flagged on the electronic patient record system. This allowed staff to identify patients that might require additional support or need support communicating.

The trust undertook audits to provide assurance the needs of patients living with dementia were met. From October 2019 to December 2019 across the surgical wards 100% of patients living with dementia were tagged on the electronic patient record system. In the same audit, 77% of patients had a completed 'This is me document' and 89% had a sunflower above the patient's bed space.

The trust supported John's Campaign. John's Campaign is the capacity for the main carer to stay with the patient during their hospital stay and to have open visiting hours. John's Campaign aims for carers to have a right to continue to care for their loved one throughout a hospital stay, should they wish to.

The service had access to information leaflets available in languages spoken by the patients and local community. This was an improvement since our last inspection when they weren't available.

Staff we spoke with knew how to book interpreters for patients who needed them. Staff understood the importance of using a professional interpreter and not using family members or friends to interpret. Staff told us that many staff spoke other languages and there was usually somebody available who spoke the desired language.

Patients were given a choice of food and drink to meet their cultural and religious preferences. There was a varied menu with options available to support individual preferences.

Specialist nurses ensured the needs of specialist patients were met. For example, patients who were leaving hospital with a stoma were given a full teaching pack, relevant equipment, contact numbers if they needed help or advice and details of support groups.

A stoma is an opening on the abdomen that can be connected to either the digestive or urinary system to allow waste (urine or faeces) to be diverted out of the body.

A range of bariatric (patients with a high body mass index) equipment was available from the equipment library. This allowed staff to safely treat bariatric patients.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards for three specialities. However, we saw the service had comprehensive actions plan to address this.

Managers and staff worked to make sure that they started discharge planning as early as possible. This started at pre-assessment for patients having elective operations. We observed a multidisciplinary meeting which discussed patients identified for discharge that day and blockers which may stop safe discharge. For example, if the equipment needed for the patient was in place at home. There was a hospital discharge planning team and they would help the wards with more complex discharges.

We saw medical outliers (medical patients on non-medical wards) occupying surgical beds. Staff told us the trust often used surgical beds for medical outliers due to a trust-wide shortage of beds. This meant beds intended for surgical patients were decreased. Data supplied to us by the trust showed across all surgical wards there was 2,405 medical outliers from October 2018 to September 2019.

An outlier team within the hospital tracked each medical outlier, to ensure they were reviewed and were receiving the right care and treatment.

Theatres monitored performance on dashboards. From January 2019 and December 2019 theatre utilisation for all theatres was 86%.

The same day emergency care unit opened in December 2019, was located next to the emergency department. The unit was open Monday to Friday 8am to 6pm and Sunday 8am to 4pm. The unit allowed patients to be seen and assessed by specialist clinicians and have access to and diagnostic scans, without needing them to be admitted to the hospital. Patients could be referred by the emergency department or patients could be referred to the unit by their GP or the ambulance service.

Staff we spoke to in the same day emergency unit were positive about the service but described a few issues that needed sorting out. For example, occasionally the senior surgeon covering the unit was operating which meant there were delays in patients being assessed. Managers and clinical staff had plans to address the issues identified.

Managers monitored waiting times. A weekly scheduling meeting was held with speciality service managers, matrons, theatre staff, pre-assessment and administrative staff. The theatre lists for the next two weeks were reviewed to ensure staff, equipment and beds were available. Managers explained that due to the change in orthopaedic services offered at the hospital some operating lists were currently empty and these were offered up to other specialities to fill.

From October 2018 to September 2019 surgical bed occupancy rates averaged 90%.

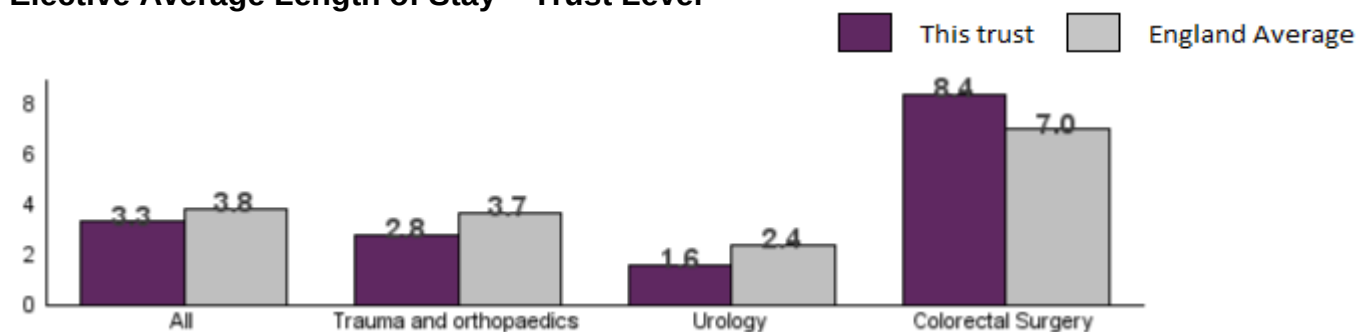
Average length of stay

Trust Level – elective patients

From July 2018 to June 2019 the average length of stay for patients having elective surgery at the trust was 3.3 days. The average for England was 3.8 days.

- The average length of stay for patients having elective trauma and orthopaedics surgery at the trust was 2.8 days. The average for England was 3.7 days.
- The average length of stay for patients having elective urology surgery at the trust was 1.6 days. The average for England was 2.4 days.
- The average length of stay for patients having elective colorectal surgery at the trust was 8.4 days. The average for England was 7.0 days.

Elective Average Length of Stay – Trust Level



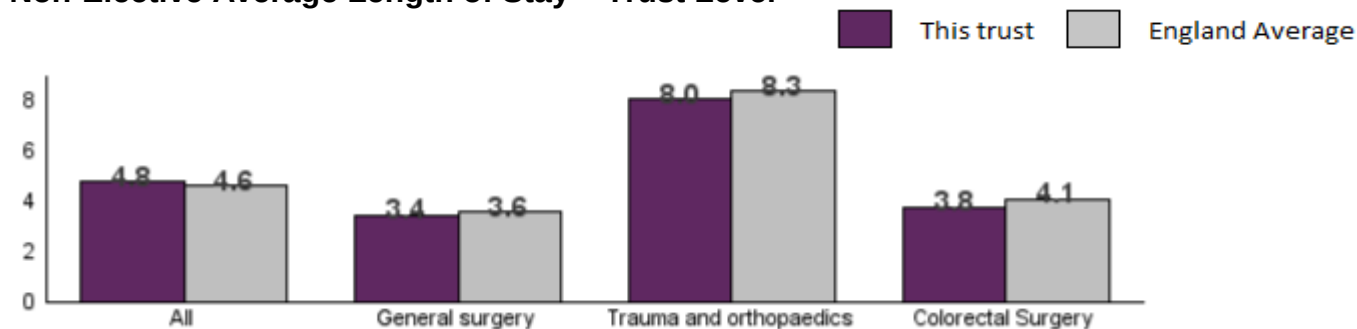
Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for patients having non-elective surgery at the trust was 4.8 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective general surgery at the trust was 3.4 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at the trust was 8.0 days. The average for England was 8.3 days.
- The average length of stay for patients having non-elective colorectal surgery at the trust was 3.8 days. The average for England was 4.1 days.

Non-Elective Average Length of Stay – Trust Level



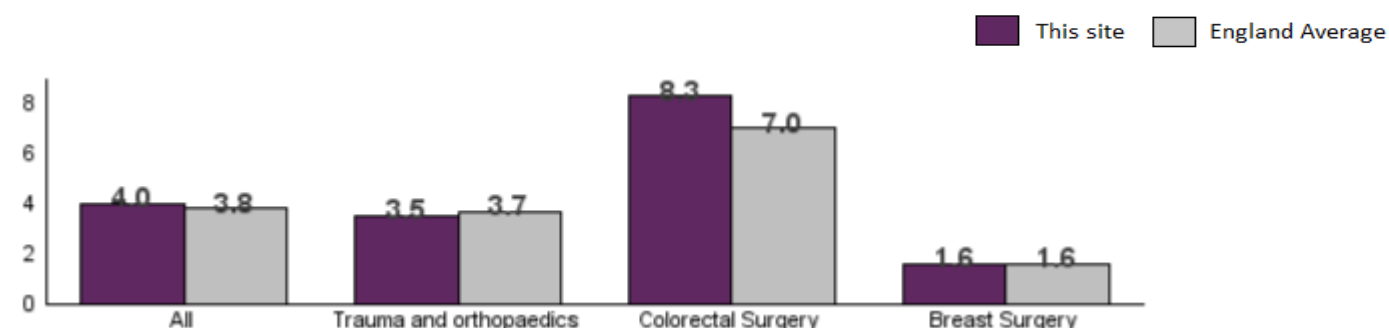
Note: Top three specialties for specific trust based on count of activity.

Royal Hampshire County Hospital - elective patients

From July 2018 to June 2019 the average length of stay for patients having elective surgery at Royal Hampshire County Hospital was 4.0 days. The average for England was 3.8 days.

- The average length of stay for patients having elective trauma and orthopaedics surgery at Royal Hampshire County Hospital was 3.5 days. The average for England was 3.7 days.
- The average length of stay for patients having elective colorectal surgery at Royal Hampshire County Hospital was 8.3 days. The average for England was 7.0 days.
- The average length of stay for patients having elective breast surgery at Royal Hampshire County Hospital was 1.6 days. The average for England was 1.6 days.

Elective Average Length of Stay - Royal Hampshire County Hospital



Note: Top three specialties for specific site based on count of activity.

Royal Hampshire County Hospital - non-elective patients

The average length of stay for patients having non-elective surgery at Royal Hampshire County Hospital was 6.1 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective general surgery at Royal Hampshire County Hospital was 3.6 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at Royal Hampshire County Hospital was 11.9 days. The average for England was 8.3 days.
- The average length of stay for patients having non-elective colorectal surgery at Royal Hampshire County Hospital was 3.8 days. The average for England was 4.1 days.

Non-Elective Average Length of Stay - Royal Hampshire County Hospital

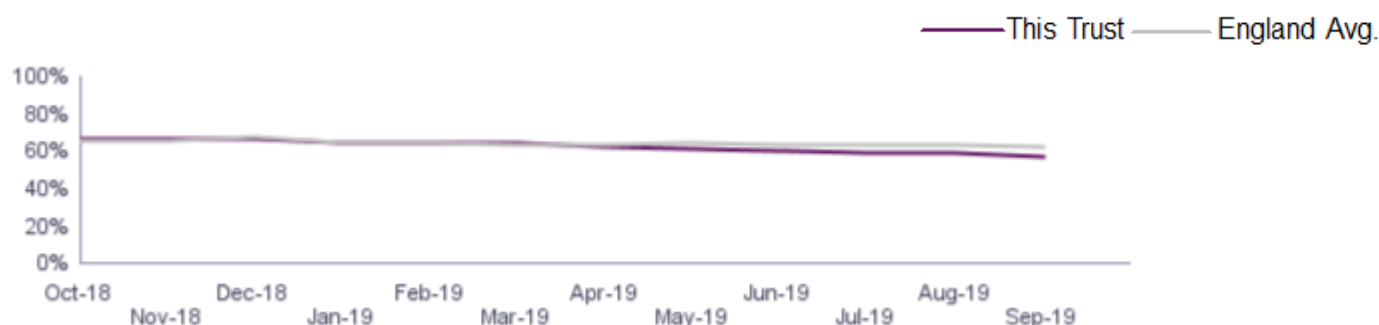


Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From October 2018 to September 2019 the trust's referral to treatment time (RTT) for admitted pathways for surgery was largely in line with the England average from October 2018 to September 2019. The trust's performance ranged from 56.5% to 66.7%, while the England average ranged from 62.3% to 68.3%.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Two specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
General surgery	76.6%	71.9%
Trauma and orthopaedics	64.4%	57.9%

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	66.9%	74.3%
Ear, Nose and Throat (ENT)	55.8%	59.7%
Ophthalmology	49.3%	61.0%

Managers and speciality leads had developed comprehensive actions plans to address referral to treatment times. We reviewed the action plans for the specialities urology, vascular, ear nose and throat and maxillofacial surgery. We saw the risks had been risk assessed and rated and there were trajectories to ensure the referral to treatment times were met. Patients that had been waiting the longest for treatment were identified and prioritised.

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

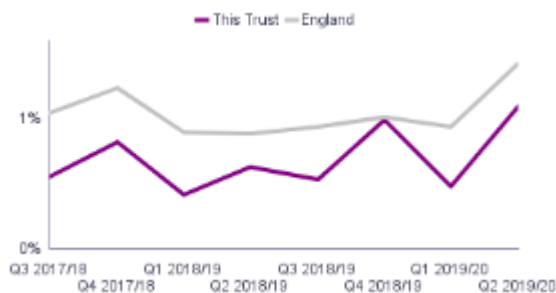
Over the two years, the percentage of cancelled operations at the trust showed that trust performance was better than the England average in three quarters, the same in same in two and worse in one quarter. In Q1 2017/18 and Q3 2017/18 the highest percentages of cancelled operations were reported with 11% and 10% of operations cancelled respectively.

Data supplied to us showed from October 2018 to September 2019 across Royal Hampshire County Hospital and Andover War Memorial hospital, there were 991 on the day or day before cancelled operations.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Hampshire Hospitals NHS Foundation Trust



Cancelled operations as a percentage of elective admissions - Hampshire Hospitals NHS Foundation Trust



Over the two years, the percentage of cancelled operations at the trust were mostly better (lower) than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Patient moving wards per admission

The trust was asked to report ward moves for the top five inpatients wards across all services at the trust. From October 2018 to September 2019, none of the surgical wards were ranked within the top five inpatient wards.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

The trust was asked to report ward moves at night for the top five inpatients wards across all services at the trust. From October 2018 to September 2019, none of the surgical wards were ranked within the top five inpatient wards.

Managers monitored that patient moves between wards were kept to a minimum. Data supplied to us showed from October 2018 to September 2019 there were 393 patients that were moved at night across the surgical wards.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. A patient we spoke to said they would raise any concerns with the matron or ward manager initially.

The service clearly displayed information about how to raise a concern in patient areas. Patients could also leave compliments, complaints or concerns on the trust's website. The website and information leaflets asked patients to identify on their complaint if they needed additional support for example an interpreter to highlight this when making the complaint. The trust made adjustments to enable all patients to complain, for example complaint responses were available in braille.

The trust website and information leaflets signposted patients and service users to independent support and advocacy agencies.

Staff understood the policy on complaints and knew how to handle them. Staff told us they tried to resolve any complaints when it happened to avoid it being made formal. The ward matrons undertook ward rounds to speak to patients to make sure they were comfortable and happy.

Staff were able to give us examples of what changes had been made in response to complaints or feedback from patients. For example, one patient had not ordered a meal so didn't have a meal at dinner time. Because of this a member of staff checks that every patient had ordered a meal.

Managers investigated and monitored complaints and identified themes. A monthly dashboard for wards and specialities monitored the amount of complaints and timelines of completion of responding to complaints in line with trust policy. The data was inputted by the ward or department lead. The dashboard also showed month on month if there had been an increase or decrease in the amount of complaints. Informal complaints were also inputted and monitored and the conversion rate of informal complaints to formal complaints made to the patient advice liaison service. For example, for the speciality of general surgery data showed in September 2019 there were fewer complaints that converted to formal complaints to the month before.

We reviewed three complaint responses each included a detailed investigation report, with evidence of review and thorough investigation by relevant staff. Responses were written in a way that people could understand.

Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed a variety of meeting meetings which showed discussion of complaints was a standard agenda item.

Summary of complaints

Trust level

From October 2018 to September 2019 the trust received 164 complaints in relation to surgery at the trust (16% of total complaints received by the trust). The trust took an average of 27.8 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be investigated and closed within 25 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	56	34.1%
Communication	31	18.9%
Admissions and discharges	19	11.6%
Patient care	19	11.6%
Values and behaviour	18	11.0%
Appointments	8	4.9%
Trust admin/policies/procedures	3	1.8%
Waiting times	3	1.8%
Access to treatment and drugs	2	1.2%
Other	2	1.2%
PDW	2	1.2%

Prescribing	1	0.6%
Total	164	100.0%

There were 48 complaints about surgery where no sites were allocated.

Royal Hampshire County Hospital

From October 2018 to September 2019 the trust received 45 complaints in relation to surgery at Royal Hampshire County Hospital. The trust took an average of 27.8 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be investigated and closed within 25 working days. However, time taken to investigate, and close complaints had improved since our last inspection when the average time was 34.7 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	14	31.1%
Communication	10	22.2%
Admissions and discharges	7	15.6%
Values and behaviour	5	11.1%
Patient care	4	8.9%
Access to treatment and drugs	1	2.2%
Other	1	2.2%
PDW	1	2.2%
Prescribing	1	2.2%
Waiting times	1	2.2%
Total	45	100.0%

Number of compliments made to the trust

From October 2018 to September 2019 there were 41 compliments received for surgery at the trust (15.8% of all received trust wide).

A breakdown of compliments by site is shown below.

Site	Number of compliments	Percentage of total
Basingstoke and North Hampshire Hospital	22	53.7%
Royal Hampshire County Hospital	19	46.3%
Total	41	100.0%

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

From October 2018 to September 2019 in relation to surgery at Royal Hampshire County Hospital, the most common theme (31% of all complaints) related to clinical treatment.

Is the service well-led?

Leadership

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

The trust was divided into three divisions, medical division, surgical division and the family and clinical support division. Each division had a director and an operational director they were supported by a nursing director and a deputy director.

The surgical division was formed of seven specialties these were, surgery, head and neck, peritoneal malignancy, trauma and orthopaedics, cancer services and critical care and anaesthetics. Each speciality had a clinical director, an operational service manager and the cancer and peritoneal malignancy divisions had a deputy operational manager. The surgery and head and neck specialties had an operational service lead.

There was one trust-wide surgical division management team that worked across the three sites. Senior management staff working in the surgical services mainly divided their time between the Basingstoke and Winchester hospital sites with an office at each location.

At a more local level, surgical wards and departments were managed by matrons and senior sisters.

During the inspection we interviewed the surgical management team to gain an understanding of the local leadership in each of the areas. We reviewed minutes of meetings, risk registers and reports to gain an understanding of the service.

Leaders were visible and approachable in the service for patients and staff. Staff told us that they felt well-supported by their line manager as well as senior leaders. Staff at all levels could identify divisional leaders as they visited wards and departments.

We saw matrons were visible on the wards and supported staff with patient care during busy times. Ward staff were positive about the leadership of ward managers and matrons within wards and departments. One comment from a member of staff about the ward manager was “they are really good, highly organised and a great leader”.

Staff in theatres were very positive about the managers within theatres and the beneficial influence they had on the departments. Comments from staff included “the best manager I have ever had” and “they will straight away deal with any issues”.

Matrons from all three divisions met once a month for an all-day meeting. This was a formal meeting overseen by the nurse director which provided a platform to discuss governance, risks, performance issues and to share learning amongst the group and have a cohesive approach to running their wards and departments. Matrons we spoke with said it was a beneficial and helpful day. It was up to the responsibility of the matrons to share information gained from this day down to their teams.

The surgical management team had an understanding of the risks to the service and monitored compliance, with recognised patient safety tools and were focussed on the quality and safety of the service.

Vision and strategy

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

The trust had four high level strategic objectives for 2018-2022. These were outstanding care for our patients, empowered staff, living within our money and innovating for the future. The strategic objectives had been developed with engagement with staff, governors, stakeholders and the board. Senior leaders were able to describe some areas of progress against the strategic objectives, such as the orthopaedic and urology transformation projects.

The strategy for the surgical division, was clearly linked to the trust's strategic aims, including financial sustainability, improve theatre productivity, move more elective procedures to day case, and more day case to outpatients, building new facilities and developed orthopaedic services. Managers had achievable plans of how to turn the strategy into action. Senior leaders were able to describe some areas of progress against the strategic objectives, such as the orthopaedic and urology transformation projects.

Staff could describe how they applied the trust values in their day-to-day work. We saw posters and computer screen savers displaying the trust values on noticeboards on the wards. The trust values were CARE; Compassion - caring about our patients and our colleagues; Accountable and responsible, always improving; Respect for all – colleagues, patients and their families and Encouraging and challenging each other to always do our best.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff said they enjoyed working at the hospital. They described the culture as “cosy and a real community feel” in theatres a staff member told us “the team is passionate, friendly and we all help each other”. We saw staff supported each other across the surgical wards and within theatres. Theatre staff explained to us that there was a real “team ethos” and how everyone helped each other so they could all finish on time rather than just finishing your list and going home.

The service promoted equality and diversity in daily work and provided opportunities for career development. However, trust diversity groups were in their infancy and still needed embedding.

We saw posters and computer screen savers with details of the trust's freedom to speak up guardian on the wards and departments. Most staff we spoke to were aware of the role but not the person's name but knew how to access them should they need to.

We did not find a culture of bullying harassment, this was a concern found at the last inspection. The majority of staff we spoke to felt respected, valued and that morale was good. Staff in theatres described morale “as constantly shifting sands” and that several long serving members of staff had left which had an impact on morale. However, with the recruitment of new staff they felt confident it would improve again.

In theatres, the culture towards the World Health Organisation Safety Checklist had improved since our last inspection. All staff were engaged and there was strong leadership of the process.

For example, we saw an anaesthetist leading the process and asking staff to stop what they were doing whilst they undertook the checklist.

Governance

Leaders used effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Governance processes throughout the service had improved since our last inspection.

The surgical division held a variety of monthly governance meetings, these included theatre governance meetings, speciality governance meetings such as orthopaedics and general surgery and surgical division quality governance meetings. These fed into the surgical board meeting chaired by the medical director, which in turn fed into executive governance committee.

We reviewed a variety of governance meeting minutes and saw they were well attended, and all different staff groups were present. At our last inspection matrons did not attend governance meetings so it was unclear how information disseminated down to ward level. Meeting minutes showed that leaders reviewed quality, safety and performance items including incidents, safeguarding, staff training, audits, complaints and patient satisfaction results to help drive improvement.

All specialties held morbidity and mortality meetings, we reviewed a variety meeting minutes. We saw minutes from mortality and morbidity meetings were standardised, thereby maximising their ability to support learning. This was an improvement since our last inspection when minutes were not standardised. We saw evidence of actions and learning outcomes which showed improvements to patient care because of these meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Managers we spoke with at all levels understood the risks to the service and could describe action to reduce risks. For example, as part of the orthopaedic transformation hip and knee replacements were undertaken at the hospital, but theatre staff did not have skills and knowledge in these procedures. To reduce the risk theatre staff from Basingstoke and North Hampshire Hospital worked with existing staff to train them on the new equipment and procedures.

The service had oversight of risks at local, divisional level. A variety of departmental, speciality and divisional meeting minutes showed risks were regularly reviewed. This was an improvement since our last inspection when meeting minutes did not include information on risks.

Operational managers in conjunction with matrons and the nursing director regularly reviewed risk registers and updated them with actions taken to reduce risks and any changes in risk ratings. The service held one divisional risk register for all three main hospital sites. The divisional risk registers fed into the trust-level risk register.

The service monitored a range of performance and outcome measures each month. They acted to address performance that fell below targets for example, the failing to meet referral to treatment targets. Comprehensive action plans with timelines had been developed to address this issue. number of medicine errors within theatres.

The service had strengthened leadership in theatres and improved the safety culture with a focus on the World Health Organisation Safety Checklist.

Theatres had implemented the National Safety Standards for Invasive Procedures (NatSSIPs) within Local Safety Standards for Invasive Procedures (LocSSIPs). NHS Improvement published the National Safety Standards for Invasive Procedures (NatSSIPs) in September 2015 to help NHS organisations provide safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical never events can occur. Staff in theatres followed Local Safety Standards for Invasive Procedures (LocSSIPs) when carrying out the World Health Organisation Surgical Safety Checklist. For example, following a specific checking process for implants during surgery.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service shared relevant performance information with staff and patients. Each ward or department lead inputted data into a data collection system which monitored a variety of different safety measures such as the number of falls and the number of pressure ulcers. This information was reviewed and shared with staff at meetings.

Safety thermometer data, staffing data and NHS Friends and Family recommendation rates was displayed in wards and departments.

The information systems were secure. We saw staff followed information governance principals, such as locking their computer screens when unattended. The majority of staff told us they were able to access the information they needed to carry out their roles.

The trust was implementing a Digital Care programme over the next three years. This aimed to improve the way the trust communicated with patients to reduce the amount of paper used and allowed patients access to more information, helping them to take control of their own care.

Doctors reported issues when trying to obtain investigation results when patients came to the hospital who were from out of the area. A new urology procedure was being undertaken and patients having the procedure done did not live in the local area. We saw a patient had to have a test repeated on the morning of surgery as staff had been unsuccessful in obtaining the investigation results from the hospital that performed the test.

Engagement

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

The service engaged with patients and invited patients back to have a coffee and a chat with the matron to give feedback on the care they received.

The trust held patient forums and community engagement events. The trust hosted an event to discuss with local people, staff and key stakeholders how they were responding to the commitments set in the national NHS Long Term Plan.

Health Focus events were held regularly in the local geographical area. They were open to everyone and included a presentation by a senior clinician on a range of health-related topics.

As part of the orthopaedic transformation project the service sought feedback from patients and their families who were affected by the changes. Each patient who had a joint replacement at the Royal Hampshire County hospital were sent a short survey to complete to gain feedback on the care and treatment they received.

We received mixed feedback from staff about their input and engagement with the orthopaedic transformation project. There were dedicated email addresses and forums that staff could access to give feedback. There were internal and external reviews of the transformation project and the effects which would be analysed and presented to staff once completed.

The surgery division had developed an action plan to address the worst performing areas in the 2018 staff survey. There were 12 action, all actions had a nominated individual and a time scale. Of the 12 actions eight had been completed. Actions included introducing 'You're amazing mugs' as local WOW awards, rotational roles for staff, a structured pathway for the first year for new staff and weekly ward rounds by members of the management team.

The trust took part in the national WOW! awards which recognised outstanding customer service. Hampshire Hospitals staff can be nominated for an award by their colleagues, patients or visitors, with a handful of winners selected by the trust's public governors each month. Wards and departments throughout the surgical service displayed certificates for any nominations and awards they had won.

Learning, continuous improvement and innovation

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

The service had improvements since our last inspection and many of the issues we found had been addressed. Areas of improvement included; improvements to the environment, medicine management, checks on critical equipment, infection prevention and control and improvements in governance systems.

The service undertook a new procedure for enlarged prostate glands taking referrals from other NHS trusts. The steam treatment, called Rezum, involved having steam injected at 1cm intervals, killing enough prostate tissue to shrink the enlarged prostate gland. Patients were able to go home on the same day and recovery was much quicker than more invasive procedures to reduce the size of the prostate gland.

Theatres had implemented innovated procedures in response to incidents that had occurred. For more information on these see the incidents, equipment and environment and medicine sections of this report.

The trust had a quality improvement strategy with the tagline 'everyone is an improver', the strategy aimed to build a culture of continuous improvements in patient outcomes and care. The trust had a quality improvement academy and steering group to support quality improvement throughout the trust. The trust had 105 quality improvement practitioners and 20 quality improvement coaches who had undergone specialist quality improvement training, they supported staff with quality improvement projects. Staff we spoke to were aware of the quality improvement and were able to give us examples of quality improvement projects. For example, in theatres there was a quality improvement project to recycle as much equipment as possible.

In theatres, a member of staff had been working with the trusts sustainability team and manufactures to recycle oxygen tubing and plastic facemasks.

The hospital held a Dementia Cafe in the morning on the 3rd Tuesday of every month at Littleton Memorial Hall. This was run by the Alzheimer's Society Winchester and offered a friendly, relaxed gathering with coffee/tea and a chat for people living with dementia and their families.

Basingstoke and North Hampshire Hospital

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Urgent and emergency care

Facts and data about this service

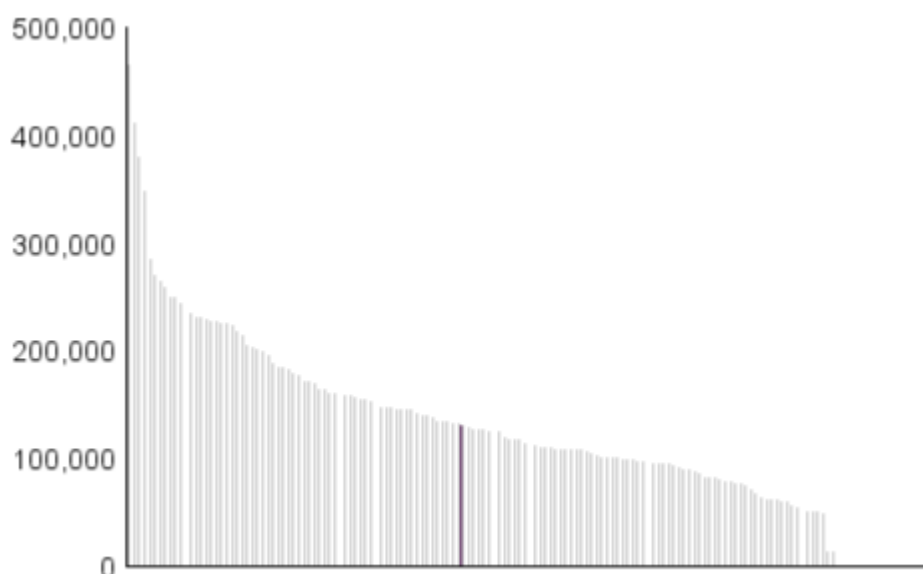
Basingstoke and North Hampshire Hospital provides an emergency service through a Type 1 emergency department. Services include trauma and cardiology, an emergency decision unit, a dedicated paediatric department and same day medical assessment for ambulatory medical patients. Furthermore, there is a minor injuries service provided by emergency nurse practitioners.

Details of emergency departments and other urgent and emergency care services

- Basingstoke and North Hampshire Hospital – Emergency department and minor injuries unit
- Royal Hampshire County Hospital – Emergency department
- Andover War Memorial Hospital – Minor injuries unit

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

Activity and patient throughput

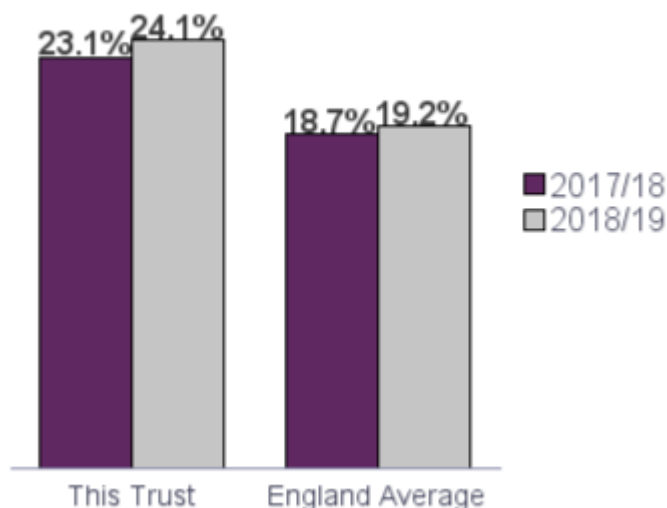


Total number of urgent and emergency care attendances at Hampshire Hospitals NHS Foundation Trust compared to all acute trusts in England, July 2018 to June 2019

From July 2018 to June 2019 there were 129,773 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

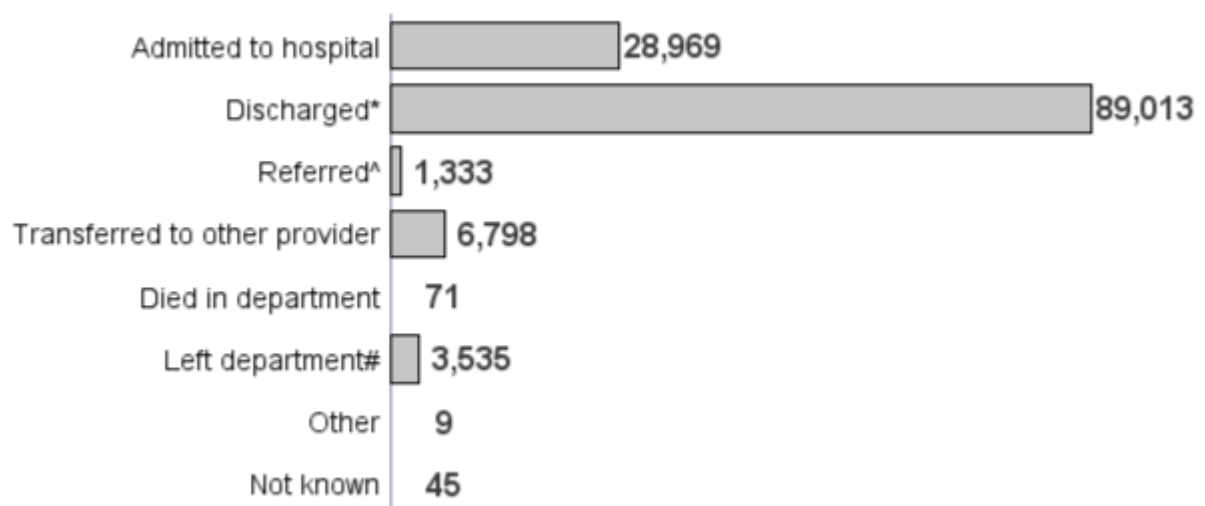
Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2018/19 compared to 2017/18. In both years the proportions were lower than the England averages.

(Source: NHS England)

Urgent and emergency care attendances, from July 2018 to June 2019



* Discharged includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Our last inspection of Basingstoke and North Hampshire Hospital's emergency department was in June 2018. We followed this up with two unannounced focussed inspections in February and April 2019.

In February and April 2019, we visited the department and looked at issues raised in a warning notice under Section 29A that was issued in June 2018. We noted that the trust had made many improvements and this resulted in the conditions of the notice being removed in December 2019.

This inspection was unannounced. We looked at the environment, equipment and observed care. We reviewed 12 sets of patients notes and looked at information provided by the trust before and after the inspection. The inspection team spoke with 10 patients and relatives, 32 members of staff including consultants, junior doctors, nurses of several grades, health care support workers, managers, allied healthcare professionals, security and domestic staff and reception staff.

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training, except for the module information governance which has a target of 95%.

Trust level

A breakdown of compliance for mandatory training courses from April to September 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below.

In urgent and emergency care the 90% target was met for four of the 12 mandatory training modules for which qualified nursing staff were eligible. Nursing staff did not meet the 95% target set for the module information governance.

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Counter fraud	164	172	95.3%	90%	Yes
Equality and diversity	164	172	95.3%	90%	Yes
Dementia awareness (including privacy and dignity standards)	164	172	95.3%	90%	Yes
Health and safety (slips, trips and falls)	162	172	94.2%	90%	Yes
Conflict resolution	151	172	87.8%	90%	No
Fire 1 year	149	172	86.6%	90%	No
Information governance	148	172	86.0%	95%	No
Basic life support	140	172	81.4%	90%	No
Immediate life support	140	172	81.4%	90%	No

Moving and handling	137	172	79.7%	90%	No
Infection control	126	172	73.3%	90%	No
Medicine management training	84	172	48.8%	90%	No

A breakdown of compliance for mandatory training courses from April to September 2019 at trust level for medical staff in urgent and emergency care is shown below.

In urgent and emergency care the 90% target was met for one of the 12 mandatory training modules for which medical staff were eligible. Medical staff did not meet the 95% target set for the module information governance.

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality and diversity	69	75	92.0%	90%	Yes
Conflict resolution	67	75	89.3%	90%	No
Moving and handling	66	75	88.0%	90%	No
Health and safety (slips, trips and falls)	65	75	86.7%	90%	No
Counter fraud	63	75	84.0%	90%	No
Dementia awareness (including privacy and dignity standards)	62	75	82.7%	90%	No
Basic life support	61	74	82.4%	90%	No
Immediate life support	61	74	82.4%	90%	No
Information governance	54	75	72.0%	95%	No
Fire 1 year	48	75	64.0%	90%	No
Infection control	45	75	60.0%	90%	No
Medicine management training	17	75	22.7%	90%	No

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

Basingstoke and North Hampshire Hospital

A breakdown of compliance for mandatory training courses from April to September 2019 for qualified nursing staff in urgent and emergency care at Basingstoke and North Hampshire Hospital is shown below.

Nursing staff received training but did not keep up-to-date with all their mandatory training. In urgent and emergency care the 90% target was met for five of the 12 mandatory training modules for which qualified nursing staff at Basingstoke and North Hampshire Hospital were eligible. Nursing staff did not meet the 95% target set for the module information governance. Of the seven modules nursing staff were not compliant with they had a higher or similar compliance to the rest of the trust. This could mean that the training for those modules were problematic across the trust rather than just on one hospital site.

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Counter fraud	94	99	94.9%	90%	Yes

Equality and diversity	94	99	94.9%	90%	Yes
Health and safety (slips, trips and falls)	94	99	94.9%	90%	Yes
Dementia awareness (including privacy and dignity standards)	94	99	94.9%	90%	Yes
Conflict resolution	91	99	91.9%	90%	Yes
Fire 1 year	86	99	86.9%	90%	No
Basic life support	85	99	85.9%	90%	No
Immediate life support	85	99	85.9%	90%	No
Information governance	85	99	85.9%	95%	No
Moving and handling	81	99	81.8%	90%	No
Infection control	70	99	70.7%	90%	No
Medicine management training	54	99	54.5%	90%	No

A breakdown of compliance for mandatory training courses from April to September 2019 for medical staff in urgent and emergency care at Basingstoke and North Hampshire Hospital is shown below.

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality and Diversity	50	53	94.3%	90%	Yes
Conflict resolution	47	53	88.7%	90%	No
Health and Safety (Slips, Trips and Falls)	47	53	88.7%	90%	No
Moving and Handling	46	53	86.8%	90%	No
Counter fraud	44	53	83.0%	90%	No
Dementia Awareness (including Privacy and Dignity standards)	44	53	83.0%	90%	No
Basic life support	43	52	82.7%	90%	No
Immediate life support	43	52	82.7%	90%	No
Information governance	42	53	79.2%	95%	No
Fire 1 year	38	53	71.7%	90%	No
Infection control	36	53	67.9%	90%	No
Medicine management training	5	53	9.4%	90%	No

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

Medical staff received training but did not keep up-to-date with all their mandatory training. In urgent and emergency care the 90% target was met for one of the 12 mandatory training modules for which medical staff at Basingstoke and North Hampshire Hospital were eligible. Medical staff did not meet the 95% target set for the module information governance. Of the 11 training modules medical staff were not compliant with at Basingstoke, they had a higher or a similar compliance to the trust as a whole. The updated compliance figures we received during the inspection for the medical staff mandatory training had significantly improved (December 2019). For example, consultant staff achieved 100% compliance in five of the modules above and 89% in three modules. Medical staff in other grades achieved 89.7% compliance across the range of modules. Managers explained that junior medical staff training was not always registered at the hospital location as much of it is completed before they began their placements.

Compliance with medicine management training was significantly lower at Basingstoke and North Hampshire Hospital for medical staff and lower than the trust target for nursing staff. Following the inspection, the trust explained that there were 31 different modules for doctors and nurses for medicines training in addition to the generic training. Staff completed the module most relevant to their role. This was not captured in the data above.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us that they were responsible for completing their own mandatory training. They told us they could access training online and face to face. One nurse told us that if they needed to complete training they were able to do so at work and the time was protected so it could be done without being interrupted.

Training included infection control, manual handling and basic life support. Staff also attended training that related to their specific role including safeguarding children and paediatric life support. Senior staff told us that level three safeguarding training was provided over 16 hours on set days. Staff told us they were looking at providing this training on other days so more staff could attend, both improving compliance and giving more staff the opportunity to increase skills in this area.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and dementia. Staff attended mandatory training in areas that included dementia awareness, mental capacity, learning disabilities and deprivation of liberties safeguarding.

Staff told us they had training in learning disabilities as part of their preceptorship training. Preceptorship training takes place in the first year in post after a nurse or healthcare professional has completed their university training. It provided support in competencies for their individual role and increased confidence and skills in their speciality, for example nursing assessment in emergency services.

Managers monitored mandatory training and had systems to alert staff when they needed to update their training. Staff told us they were able to access an online system, green brain, introduced in 2019, where their individual training was recorded. This showed them their level of compliance with mandatory training and told them when they were due to update topics. This was workplace specific so allowed them to make a personal and department focused record. Staff were told if their training was due and managers kept electronic records to monitor this.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April to September 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	161	172	93.6%	90%	Yes
Safeguarding children (level 1)	131	172	76.2%	90%	No

In urgent and emergency care the 90% target was met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

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

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	60	75	80.0%	90%	No
Safeguarding children (level 1)	37	75	49.3%	90%	No

In urgent and emergency care the 90% target was not met for either of the safeguarding training modules for which medical staff were eligible.

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

Basingstoke and North Hampshire Hospital

A breakdown of compliance for safeguarding training courses from April to September 2019 for qualified nursing staff in urgent and emergency care at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	94	99	94.9%	90%	Yes
Safeguarding children (level 1)	84	99	84.8%	90%	No

Nursing staff received training specific for their role on how to recognise and report abuse. The 90% target was met for one of the two safeguarding training modules for which qualified nursing staff in urgent and emergency care at Basingstoke and North Hampshire Hospital were eligible. We noted staff at Basingstoke and North Hampshire Hospital had a higher compliance with safeguarding training than the staff at trust level in urgent and emergency care. We spoke to four members of staff who told us they knew how to identify and raise a safeguarding.

A breakdown of compliance for safeguarding training courses from April to September 2019 for medical staff in urgent and emergency care at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	45	53	84.9%	90%	No

Safeguarding children (level 1)	27	53	50.9%	90%	No

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

Medical staff received training specific for their role on how to recognise and report abuse but were not compliant with training targets. The 90% target was not met for either of the safeguarding training modules for which medical staff in urgent and emergency care at Basingstoke and North Hampshire Hospital were eligible. However, staff had a higher compliance in both modules than medical staff at trust level. Following the inspection, we requested the most recent figures which showed safeguarding training compliance had improved. Data for December 2019 showed the consultant medical staff compliance rate had improved to 100% for safeguarding adults and 89% for safeguarding children. Other medical staff grades achieved 87% for safeguarding adults and 82% for safeguarding children.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they were able to attend a weekly drop in session on a Friday to discuss any safeguarding concerns. The trust told us that there was a monthly safeguarding meeting where the Safeguarding lead fed back on safeguarding audits and referrals received. There was a hospital safeguarding team for children, this included staff who responsible for children being looked after by foster parents and carers. We read a Safeguarding policy that outlined the training expectations of staff, how to supervise children and how to manage allegations of abuse. Staff with roles that had responsibility for children were expected to have level three training. Data received after the inspection told us that 139 staff in unscheduled care were trained to level three. This included all grades of medical staff, nursing staff, health care and general assistants.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they knew how to make a safeguarding referral for both adults and children. Staff told us they used an email address to refer adults, for children they completed a yellow form for the notes and an interagency form online. Staff told us they used a checklist in the paediatric referral form. One nurse told us they had done both and received a very quick response to the referral. Out of hours, staff told us they would complete the forms, raise it with the nurse in charge and the doctor looking after the patient or contact the paediatrician on call. Staff making a referral for a child told us they would have feedback following the referral with learning points. They told us this was very helpful.

Staff followed safe procedures for children visiting the unit. Staff working in the paediatric unit told us they had training in safeguarding children and were able to talk to the child safeguarding lead if they needed advice. At the last inspection, there was not always a minimum staffing level of one paediatric trained nurse on duty for each shift. At this inspection, senior staff told that the department had paediatric trained staff on each shift and that staff attended paediatric study days to maintain their skills. We spoke to staff in the paediatric unit who told us they had specialist training.

Cleanliness, infection control and hygiene

The service controlled infection risk. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. Seats were all made from a wipeable material which helped prevent the spread of infection. The waiting area in both the emergency department and paediatric unit were clean and tidy. Toys in the paediatric units were cleaned regularly by staff and the play specialist.

However, the corridor between the department, plaster room and fracture clinic was dusty where there were building works being completed. We were told that this was the relocation of the plaster room and was a temporary situation. We saw a four seated bench and two individual chairs that had tears in the material, which did pose a risk to infection control. We were told by staff this was the temporary waiting area for patients using the plaster room. However, we did not see them being used during this inspection. Patients in the department were seen in the department or taken straight into the plaster room and did not wait outside.

The service generally performed well for cleanliness. At the last inspection, we saw that there was litter in waiting areas and cleaning of the department was irregular. This time the areas were clean and litter free. However, the resuscitation area was cluttered in some places. There was a cupboard which was unlocked and drawers inside were broken. This restricted access to equipment. The October 2019 PLACE score showed the department passed most areas, but it was noted that the department required some building repairs. The infection control team audited the department every six months. Following the inspection, we saw audit results. Between May and November 2019, the department had improved scores for equipment, utility rooms and department patient areas, however sharps storage remained at 70% compliance and required re-auditing. The November 2019 PLACE scores showed the paediatric unit was praised for being clean and tidy, and staff praised for having a very positive attitude towards the new unit.

Cleaning records for the department were up-to-date and demonstrated that all areas were cleaned regularly. However, the disposable curtains in the plaster room in the paediatric unit were overdue to be changed. They required changing in December 2019 and were out of date by two weeks. Trust policy was to change the curtains every six months.

Staff followed infection control principles including the use of personal protective equipment .

Staff appropriately isolated patients who had a suspected infection to prevent the spread of germs. We saw this in streaming when a patient was moved into isolation immediately a viral infection was suspected. Staff

Hand sanitisers were available throughout the department. However, at the entrance to the reception area, one of two sensor dispensers were not working. The department had dispensers operated by sensors at the entrance, and manual pumps in other areas. Staff said that sometimes patients did get confused as to how the dispensers worked. On the last inspection, we noted that staff were not always bare below the elbow. On this inspection all staff were bare below the elbow while on duty.

Outside bay three in majors one, was a notice board to highlight the importance of good hand hygiene. Information on the board included; when to wash hands, how to prevent healthcare-associated infections and a hand hygiene audit result. However, the hand hygiene audit result displayed was for January to June 2018, which meant the information was out-of-date. Following the inspection, we requested the most recent hand hygiene audits for the department and saw they were completed regularly. The infection control team audit carried out every 3 months recorded 100% compliance in December 2019 while the department from the same month recorded 70%. Action plans were for feedback to individuals and staff groups during the weekly communication meeting.

We saw staff washing their hands between patient contacts. We also saw staff using aprons and gloves correctly, removing them after contact with patients and disposing of them in the correct waste bins.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The department had a team that were responsible for the maintenance and cleaning of equipment. During the inspection, we saw trolleys being cleaned after use. After cleaning equipment, staff attached a green tag to the equipment with the date it had been cleaned. This meant staff were able to identify that the equipment was clean and ready for use.

We saw storage cupboards were cluttered and untidy. In the main department, the main storage cupboard was small but fitted with shelving. The shelves were labelled but, in some cases, the items in boxes did not match the label. This meant items could not be found quickly if they were needed. Boxes were stored on the floor and items on top shelves hung over the edge of the shelves. This meant that items could fall from the shelves and cleaning could not take place without removing the boxes. However, we checked 20 items and found all were within their expiry dates.

Environment and equipment

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

The design of the environment did not always meet national guidance. Overall the department was tired in appearance. There was damage to walls that exposed concrete under the plasterwork as a result of door handles knocking into walls. There were chips in the wooden frames of doors and in the doors themselves. This provided an infection control risk as they could not be adequately cleaned as the surfaces were porous. Following the inspection, we saw the department environmental audit for November 2019. Actions included plans to repair plaster and areas of damage in the department, but the audit noted that the time frame for the repairs would be several months due to the amount of work required. The audit was to be repeated after six months so the risk could be reviewed and an updated action plan made. However, senior staff were aware of these issues and discussed them regularly with managers as part of the business and environmental improvement planning process. Senior staff showed us radiators that had already been replaced to increase space in corridors and told us that there was work in progress to relocate plaster room.

Signage in the emergency department and from the main hospital corridor was limited and unclear. This meant that patients and visitors found it difficult to navigate around the department.

Doors leading to the department had locking mechanisms that required a key card to operate. However, a door leading from the reception waiting area to the rapid assessment and treatment area was unlocked. We raised this issue with staff. Staff raised the issue with security and the door was secured before we finished our inspection of the area.

The waiting room was visible from the reception desk and treatment rooms opened into the main waiting area so staff were able to see the waiting when they were not assessing patients. In majors most of the cubicles were visible from the main staff area in the centre of the department. However, room 12 situated between the resuscitation area and patients in the corridor was not clearly visible at all times. A nurse told us the room was risk assessed to ensure it was suitable for the patient using it.

The emergency nurse practitioners told us they used assessment rooms but also saw patients in cubicles in the corridor between the waiting area and the paediatric unit. These cubicles had trolleys and curtains but were observed by staff when in use.

The service had facilities to meet the needs of patient's families. There were 38 seats in the main waiting area. However, all seats were the same specification which meant there may not be seating available for those who require a higher seat or for bariatric patients. However, this was recorded as a concern in the Patient Led Assessment of the Care Environment (PLACE) audit of October 2019 but an action plan for addressing this was not recorded. We saw a separate waiting area for children in the main waiting room for patients who had children with them.

There was an assessment room within the paediatric unit that was available to use by the children and adolescent's mental health team or as a quiet space for other patients. The room had two doors and basic décor including child friendly murals. There were no ligature points, and lightweight furniture that could be removed if required. There was a strip alarm that ran around the walls of the room which meant it could be easily reached from anywhere in the room and could be pressed by staff and patients to call for help

We saw the plaster room in the paediatric unit had plaster tools left out on surfaces. While patients were not left alone in this area it increased the risk that items could be moved or knocked accidentally. Suction and oxygen catheters were tied in bundles that would be hard to open in an emergency. However, there were no ligature points.

We saw the toilets in the paediatric unit, were suitable for disabled use and had baby changing facilities. The main department and waiting room was easily accessible for pushchairs and those with mobility challenges.

Patients in the main department and resuscitation area could reach call bells and staff responded quickly when called. We noted there were no call bells in the paediatric unit or resuscitation area. However, there were emergency buzzers, so staff could call for assistance. Staff told us that patients were not left alone in these areas as they were either with relatives in paediatrics or staff in the resuscitation area. The paediatric unit was locked with secure electronic access using a swipe card. Each room in the unit had close circuit television.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were tamper evident and locked with secure tabs. This meant that it was easy to see if the trolley had been opened and prevented unauthorised access. Staff completed daily checks of the trolleys to make sure that all the contents were present and in date. We looked at the checks recorded from 1 January to the date of the inspection, 15 and 16 January 2020. However, we saw that the check for the trolley in majors had not been completed on one day and the trolley in the paediatric unit had not been completed on two days.

We saw the resuscitation trolley in the paediatric department was cluttered. The trolley had three drawers and each drawer was labelled. All the equipment in the trolley matched the checklist. However, not all equipment was stored in the correct drawer and one drawer was labelled incorrectly. This meant staff might not be able to access the correct equipment at first sight unless they were familiar with the storage system. This was raised with the trust immediately and emailed to all departments for immediate action.

In the resuscitation area we reviewed the paediatric bay. We noted that all the disposable and single use dressings or equipment were sealed in packets, labelled and in date. However, the area was also cluttered and had limited child friendly décor.

The service had enough suitable equipment to help them to safely care for patients. Most pieces of equipment checked were tested and within their review date. We checked 16 pieces of equipment and found all but one piece of equipment had received electrical safety testing. We notified the housekeeping team, responsible for equipment maintenance, who removed the piece of equipment from the department. Staff had a record of all the equipment in the department. They were able to arrange for equipment to be repaired and were also contacted by the servicing team a week before the expiry date to send equipment for routine testing. This has not happened for the one piece of equipment as it has been in another department until that day and was due to be replaced.

We asked staff how they would identify if a piece of equipment was safe to use. Staff were able to identify the electronic safety testing stickers and indicated that they would only use the equipment if the next test date had not passed. Any member of staff was able to request a repair and would complete a form for the housekeeping team to forward to the maintenance department with the equipment. Staff told us they would tell the nurse in charge and label the equipment as broken.

Clinical waste was generally disposed of safely. We saw staff using the correct bins for disposing of aprons, gloves and clinical waste such as dirty dressings, linen and bed pans. The dirty utility room in the main department was tidy and accessible through two doors. We saw three commodes were visibly clean and labelled ready for use. There was a cupboard for the storage of cleaning solutions that was locked and there were no cleaning solutions left on show. Clinical waste bags in the room were separated and stored safely in cages or trolleys. There was a smaller utility room in majors two that was also clean and tidy.

We checked seven yellow sharp bins. Sharp bins should be signed and dated on the day the bin was opened, with location and area information also recorded on the bin. However, one of the bins checked had illegible writing on it, which made it hard to identify the hospital and area the bin was being used in. Two other bins had no information completed but were in use.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. In 2018, the department did not use early warning scores and there were long time periods between patient observations. In 2019, these tools were in place but not consistently used. On this inspection, staff used the national early warning score (NEWS2) to monitor and record clinical deterioration in adult patients and the paediatric early warning score (PEWS) for children. We saw pathways displayed in the department that acted as prompts for staff assessing patients. These included a fractured neck of femur pathway, sepsis protocols used in all areas. We saw the department used a sepsis bundle to assess and treat patients with possible sepsis. The bundle was a nationally recognised tool with six steps for testing for sepsis and starting treatment within one hour of it being identified.

Staff told us that doctors had access to the electronic patient record to review ReSPECT forms (Recommended Summary Plan for Emergency Care and Treatment), used alongside Do Not Attempt Cardio Pulmonary Resuscitation orders (DNACPR). They told us that if a patient attended the department with an active DNACPR the team would act accordingly. If this was not available, the senior team would make a clinical decision.

Staff told us that they would call 2222 if they required assistance or the emergency buzzer for a medical emergency. They told us that doctors would make a call to specialist teams for further assistance if necessary. We saw the team respond rapidly to a patient who had collapsed in a cubicle. The emergency buzzer was activated immediately and the response from the team was appropriate and timely. Initially there were a large number of staff responding and we were unsure who was taking the lead, but the team gave appropriate care and the patient transferred to the resuscitation area. The patient did not have a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order but this was discussed and completed after the patient became unwell.

Staff completed risk assessments for each patient on admission and arrival, using a recognised tool which they reviewed regularly, including after any incident. On this inspection senior staff told us there were two routes for admission into the department for patients. Patients who were able to walk into the department were first seen in the streaming area. Here we saw a nurse and healthcare assistant take initial information and complete an assessment. Staff here could take the patient into a separate room if the assessment needed a more thorough discussion. Staff told us they would then direct the patient to reception to sign in while waiting to see a nurse practitioner or GP. If the patient was assessed as needing to be seen in the main department they were then taken either to the rapid assessment and treatment area (RAT), directed to the main department, paediatric unit or resuscitation area.

Staff in the streaming area were able to make rapid decisions on which area the patient needed to be seen in. Staff described the process for four patients seen on the 16 January 2020 and we saw the protocol used to confirm this had been followed correctly. Senior staff told us that if the streaming area became very busy, a senior nurse would talk to each patient to quickly identify those at risk of deteriorating if they waited too long. Senior managers told us they were looking at developing discharge pathways that nurses in streaming could use. During this inspection, we were told nurses in this area did not discharge as part of the streaming pathway and referred to a doctor for the final decision.

Patients attending by ambulance were brought to the rapid assessment and treatment (RAT) area by the ambulance staff. Rapid assessment and treatment was a process where senior emergency department staff assessed patients as early as possible so they could be moved to the correct area for treatment. This meant that decisions could be made quickly and reduced the wait for a patient to be assessed by the correct team. The area had four bays and was staffed by two nurses and a health care assistant with support from doctors when needed. We saw nursing staff receiving handover from ambulance crews before the patients were admitted to the main department, paediatric unit or resuscitation area. After the inspection we saw the standard operating procedure for the area. This reflected the processes we saw in action on our visit.

During this inspection, the department was busy however, we did not see ambulances waiting outside the department. The national standard is for patients to be handed over to staff and for assessment to begin within 15 minutes. Staff told us that if the area was busy a senior member of staff would assist in assessing patients. Staff told us they would try to complete assessments, such as electrocardiograms which show the heart rhythm and electrical activity as a graph, before transferring the patient to the main department. If a doctor was working in the area they would also assess, treat and discharge patients rather than transfer them into the department. This meant that the service was able to respond to changes in activity within the area and maintain flow into the hospital. Nurses told us they were able to follow set pathways to assist in directing patients to the correct service. These included early pregnancy and breathlessness referral pathways.

Alongside the main department there was majors two. This area was used for patients who were 'fit to sit' and were directed there from rapid assessment and treatment or streaming. Patients in this area were awaiting further tests and could be assessed in one of two cubicles or a side room. The area was staffed with two nurses and a health care assistant. Staff told us that this staffing level was appropriate, unless the area became busy, then they would request additional help from the main department. Staff also told us they would support staff in the corridor if there were patients there. The staff were able to explain that if there was any deterioration in the patient's condition, the team would use the assessment cubicles, request the doctor review the patient and possibly transfer the patient back to the main department. Staff told us they followed a standard operating procedure to identify which patients were safe to be in the 'fit to sit' area. They ensured they received a handover from the streaming or rapid assessment and treatment staff. The decision to discharge was made by a doctor who prescribed medicines which were collected from the outpatient pharmacy by the patient.

While we were in the department we saw a child admitted to the paediatric assessment unit with a fracture. We saw they were given pain relief quickly and seen by a doctor on arrival. The patient was taken to x-ray rapidly and then to the resuscitation area for ongoing monitoring. We were told the patient would normally go to the resuscitation area first, but the team were able to access x-ray quickly which ensured the patient was seen and assessed promptly.

We saw the department receiving trauma calls. The senior staff used a pre-set criterion to create a pre-alert to forewarn the department of a trauma patient arriving at the hospital. This was displayed on a screen, so staff could anticipate ambulance arrivals. Staff would notify the team and allocate staff to the correct area using a tannoy. The trauma nurse lead would be paged to the department. We saw a patient brought to the hospital as a trauma call and noted that the ambulance crew were able to hand over the patient in the rapid assessment and treatment area. They were seen by a consultant and transferred into the main department. We noted that this was the right response for the clinical need of the patient.

Senior staff told us that they have worked alongside the specialist falls nurse and the tissue viability nurses to develop a joint record for the risk assessment of falls and pressure areas. The team will trial this in February 2020 and will be used in both hospital emergency department sites.

In the paediatric unit, there were clear escalation guidelines on the wall which acted as an aide memoir for the nurse in charge.

Following the inspection, we saw the psychiatric triage tool used by the team to assess vulnerable adult patients. This guided staff on who to contact and when for mental health assessment.

Staff knew about and dealt with any specific risk issues. In streaming, where patients walked into the department, we saw a patient assessed for potential flu symptoms. Staff told us that while they were being assessed by the nurse, a room was being found so they could be kept isolated from other patients. We saw the patient being moved within five minutes of arrival into a room in the rapid assessment area, and soon afterwards into majors. The nurse told us that the patient was not assessed in the streaming room to avoid the room being potentially contaminated and needing a deep clean. This would have meant the streaming assessment room would have been unavailable for several hours and could have delayed assessment of the next patients arriving. The nurse told us that the patient had consented to being seen in the waiting area. We noted that this was an appropriate clinical decision for the patient and others in the department.

Patients cared for in the corridor were placed on trolleys with pressure relieving mattresses. Staff told us that these mattresses could have air added to increase protection for patient's skin. Staff

told us a body map was completed which recorded any pressure sores, injuries or bruising on admission. They told us that further checks were made but not always recorded. However, senior staff told us that they aimed to only place patients in the corridor who were mobile or due to be transferred to a ward. Senior staff told us that they booked two members of staff to look after patients in the corridor. We saw that on the wall beside each patient was a sign stating the name of the nurse looking after that patient. We heard staff offering patients food and drink while they were in the corridor and saw they had overbed tables to keep food and drink close by.

We spoke to clinical and administration staff who told us they had training in conflict management. Staff told us that they would try to de-escalate challenging behaviour by talking to the patient and using positive body language. We were told that they felt very well supported by senior members of the team when such incidents occurred. In the main department, staff could let patients or relatives have time in the relative's room time to calm down.

Staff told us they were not trained to use restraint but had to become involved in restraining patients who were violent and aggressive when administering rapid tranquilisation medicine. Rapid tranquilisation medicines are medicines used to sedate patients who pose a risk to others and/or themselves. Security staff were trained to restrain individuals and trained to level three in conflict resolution. They told us that porters were trained to level two with some also trained to level three. The training included recognising factors that increase the risk of aggression, managing confrontations and the use of reasonable force. Guidance from the National Institute for Health and Clinical Excellence (NICE) states that staff should be suitably trained if they need to restrain patients (NG10) and the department was compliant with this. These skills enabled them to take the lead in the process with nurses and doctors present. If a patient had to be sedated by doctors, the security team told us that they would not restrain the patient unless the doctor documented the need to. Following the inspection, we were shown the guidelines used for rapid tranquilisation. However, these did not reference the trust policy.

The hospital had two security guards on site at all times who were trained in restraint. However, they worked throughout the hospital and while they tried to prioritise incidents in the emergency department they could not always safely restrain patients on their own and would respond as a team.

Following the inspection, we were shown the draft restraint policy and the policy for paediatrics which reflected the process we were told by staff. Between July and December 2019, there were 12 incidents relating to patient restraint with the emergency department at BNHH. In each case, clinical and non-clinical staff followed the restraint policy.

Staff told us they used rapid tranquilisation only after all other ways to manage the patient's challenging behaviour were considered. These included trying to calm the patient verbally, moving them away from others and any areas that were distressing them. If the patient had to be sedated, they were moved to the resuscitation area to be monitored. This was in line with the trust's policy on rapid tranquilisation. We saw a chart that described how to check the patient and what signs to look out for if the patient became unwell.

Security staff told us that the police were sometimes called to support and help the hospital staff. However, on some occasions the police were unable to support, and the security staff had to manage the situation. Security staff told us they were alerted by the ambulance staff if a patient was known to be aggressive and was being brought to the department. They reported they have a good rapport with the department and hospital managers who have thanked them after some incidents where staff have been injured by patients. The team are waiting for agreement to trial the

use of body cameras. This would allow the team to monitor their interventions and provide information on incidents afterwards.

The service included round the clock access to mental health liaison and other specialist mental health support if staff were concerned about risks associated with a patient's mental health. Senior staff told us that they were able to book a registered mental health nurse within an hour during the day and booked a registered mental health nurse to work within the department every Friday and Saturday night. They were present in the department from 7.30pm to 8am the following morning. This decision was made in response to an increase in the number of patients attending the department with complex mental health needs.

Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff told us that they were able to access support to assess patients at risk of self-harm as soon as it was identified. However, we were informed by colleagues that in one case a patient's mental health needs were not recognised in the emergency department and were identified on a ward a day later. The patient had reported a low mood to ward staff and that they were not coping. We were told that the ward had referred the patient for assessment and ongoing support. We were unable to establish if the patient had expressed this to emergency department staff and if a mental health assessment had been indicated at the time.

Staff shared key information to keep patients safe when handing over their care to others. Nurses told us they were able to request help from doctors in managing patients and that the doctors respected their judgement.

Shift changes, board rounds and handovers included all necessary key information to keep patients safe. A safety huddle was held daily to review the pressures and risks from the previous day, and how this would impact the department and service for the next day. We saw a handover led by the nurse in charge where doctors and nursing staff discussed each patient and allocated jobs to each staff member. The meeting was held in the sister's office. More handovers were held at 7.30am and 7.30pm. We were told at the morning meeting the night nurse co-ordinator gave a report of activity overnight, the number of beds in the department and patients being cared for in the corridor. Staff told us they were given areas of the department to work in and then had a clinical handover in that area. We saw the staffing sheet that was completed at this meeting and a daily safety check list was handed over for the day staff to complete.

Emergency Department Survey 2018 – Type 1 A&E departments

The trust scored about the same as other trusts for all five emergency department survey questions relevant to safety.

Question	Trust score	RAG
Q5. Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.6	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.4	About the same as other trusts
Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.3	About the same as other trusts
Q33. In your opinion, how clean was the A&E	8.4	About the same as other

department?		trusts
Q34. While you were in A&E, did you feel threatened by other patients or visitors?	9.7	About the same as other trusts

(Source: Emergency Department Survey 2019)

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

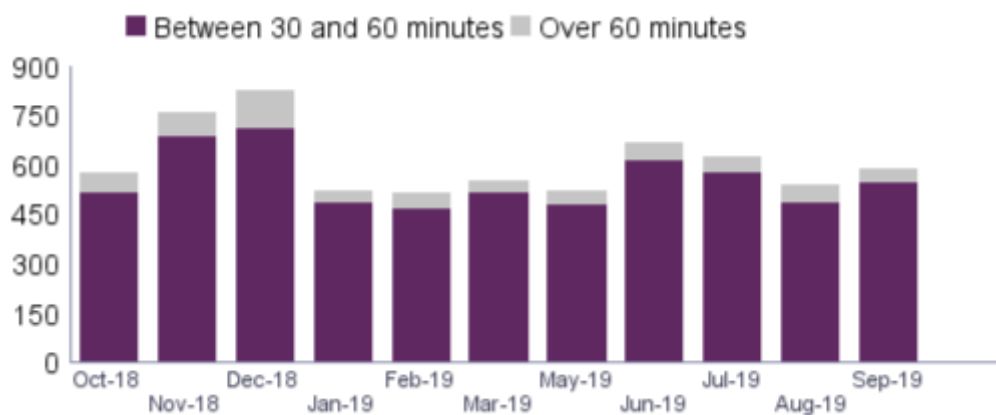
The median time from arrival to initial assessment was better than the overall England median from October 2018 to March 2019.

Basingstoke and North Hampshire Hospital has streaming at the front door and therefore has a median time to initial assessment of zero.

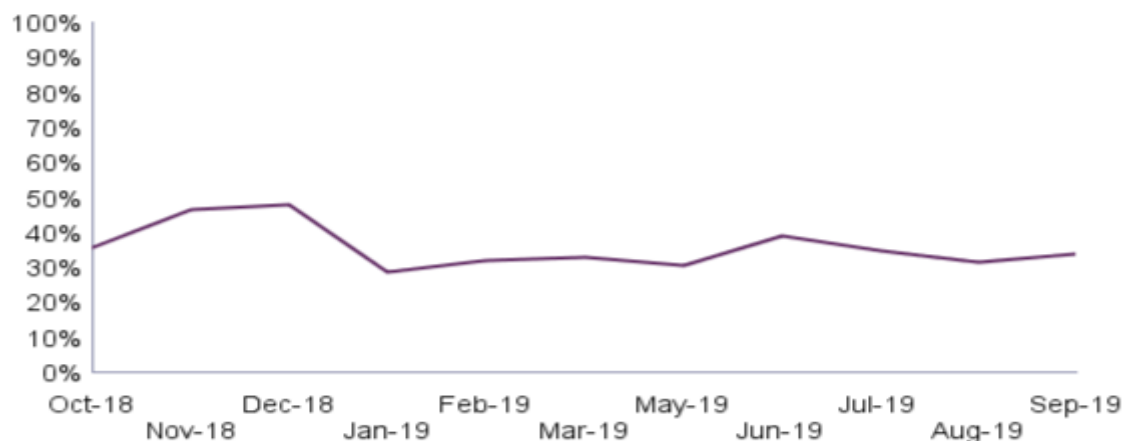
Percentage of ambulance journeys with turnaround times over 30 minutes for Basingstoke and North Hampshire Hospital

From October 2018 to September 2019 there was mostly a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Basingstoke and North Hampshire Hospital. However, higher percentages of turnaround times were recorded during the winter months of November and December 2018.

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



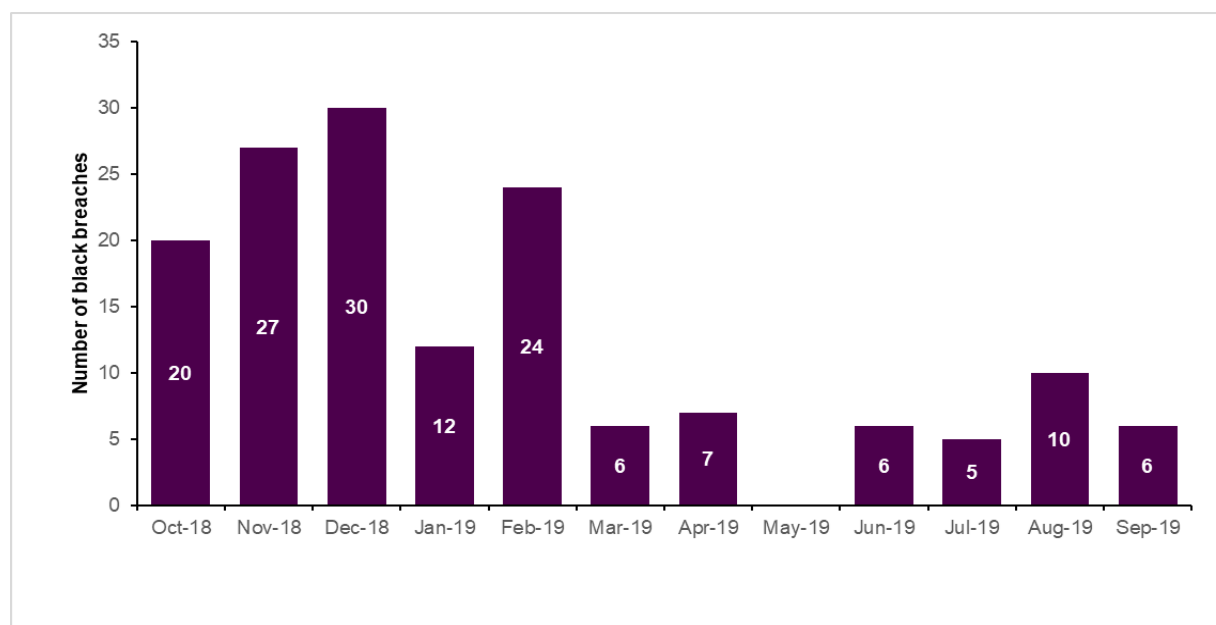
Ambulance: Percentage of journeys with turnaround times over 30 minutes – Basingstoke and North Hampshire Hospital



(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From October 2018 to September 2019 the trust reported 153 “black breaches”.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

The service had a process to escalate ambulance handovers if there were more than three patients waiting or if the handover was taking more than 15 minutes. This was rated red, amber and green to identify the waiting time, red being over 45 minutes, amber between 15 and 45 minutes and green under 15 minutes. This enabled the department to monitor and escalate concerns if the area was approaching black breaches.

Nurse staffing

The service generally had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Trust level

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at trust level compared to the trust's targets, where applicable:

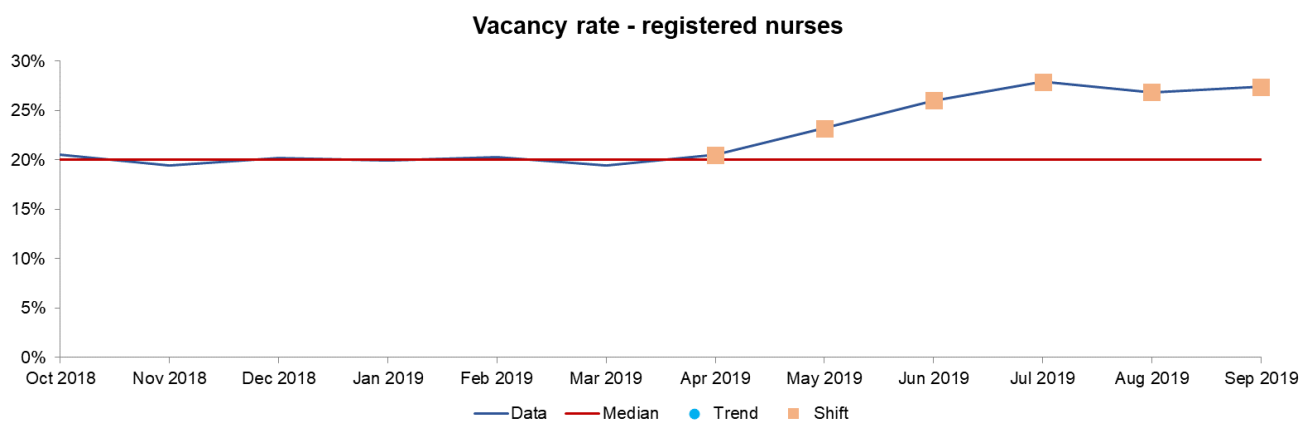
Staff group	Urgent and emergency care annual staffing metrics						
	October 2018 to September 2019						
	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours

					(% of available hours)	(% of available hours)	(% of available hours)
Target		8%	12%	3.5%			
All staff	432	14%	16%	4.7%			
Qualified nurses	193	23%	10%	4.3%	39,001 (11%)	77,735 (23%)	7,401 (2%)

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

Vacancy

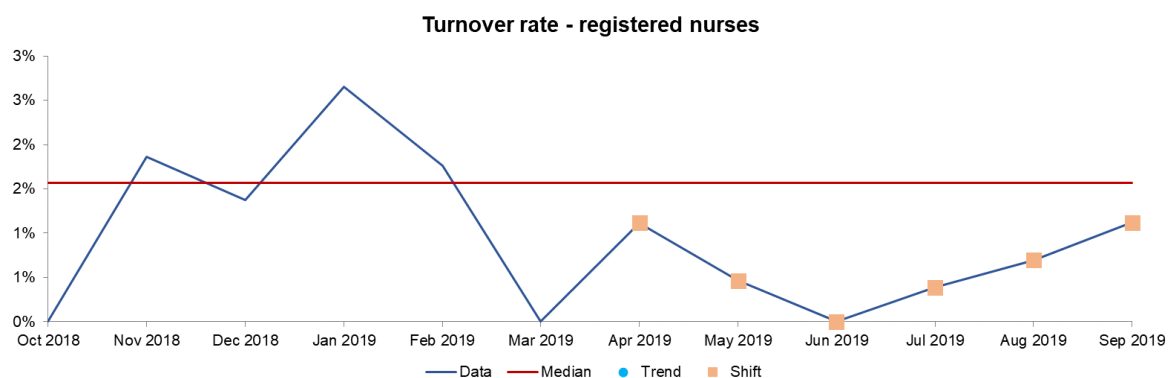
The service had low vacancy rates with an increasing trend towards September 2019.



Monthly vacancy rates over the last 12 months for qualified nurses shows a shift from April 2019 to September 2019. This could be an indicator of change.

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

Turnover rates

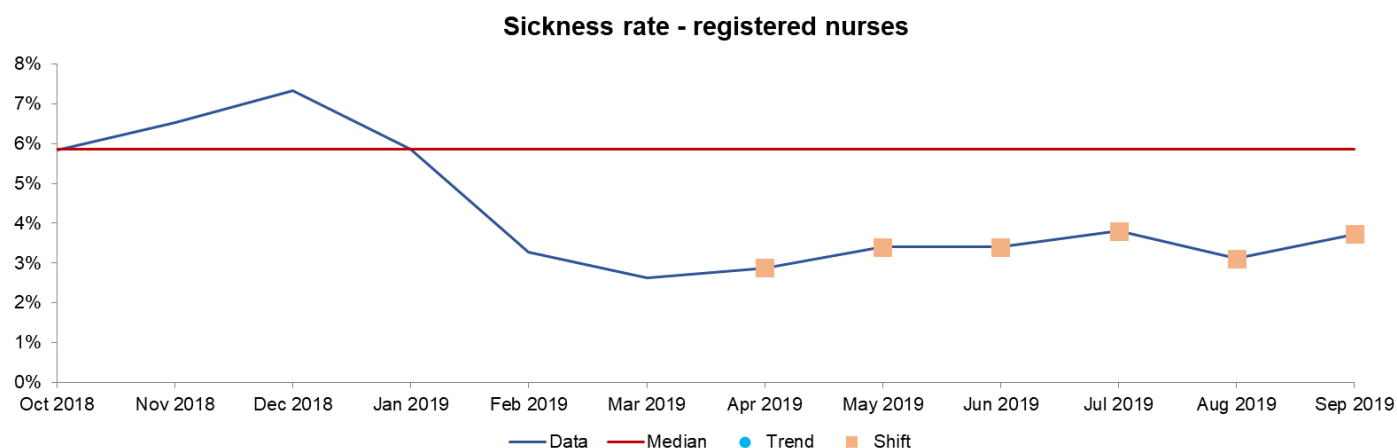


Monthly turnover rates over the last 12 months for registered nurses show a downward shift from April 2019 to September 2019.

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

Sickness rates

The service had a low and reducing sickness rates.

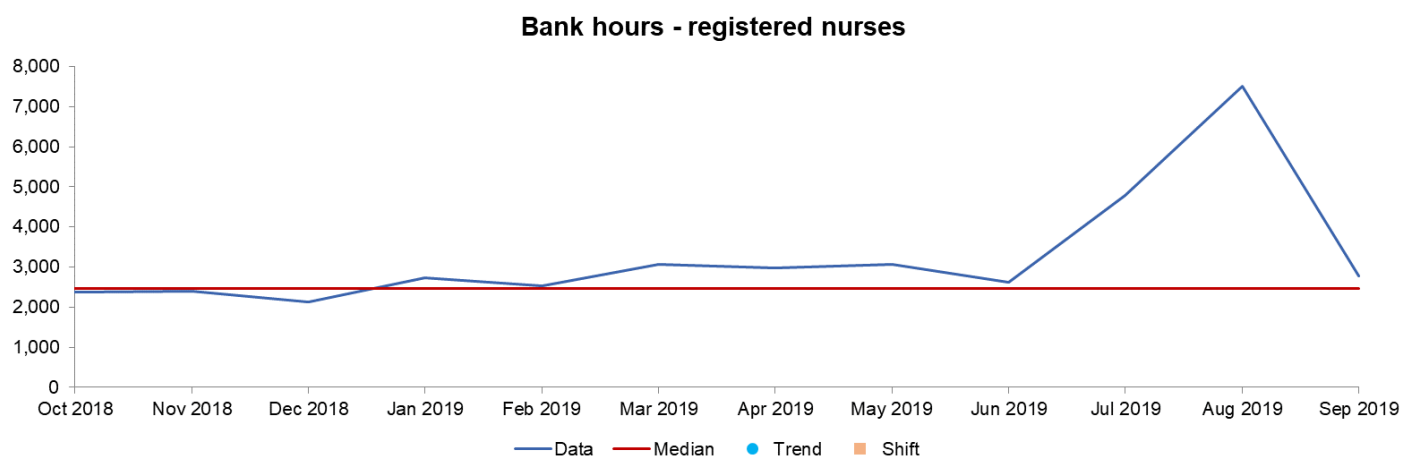


Monthly sickness rates over the last 12 months for registered nurses show a downward shift from April 2019 to September 2019. This could be an indicator of change.

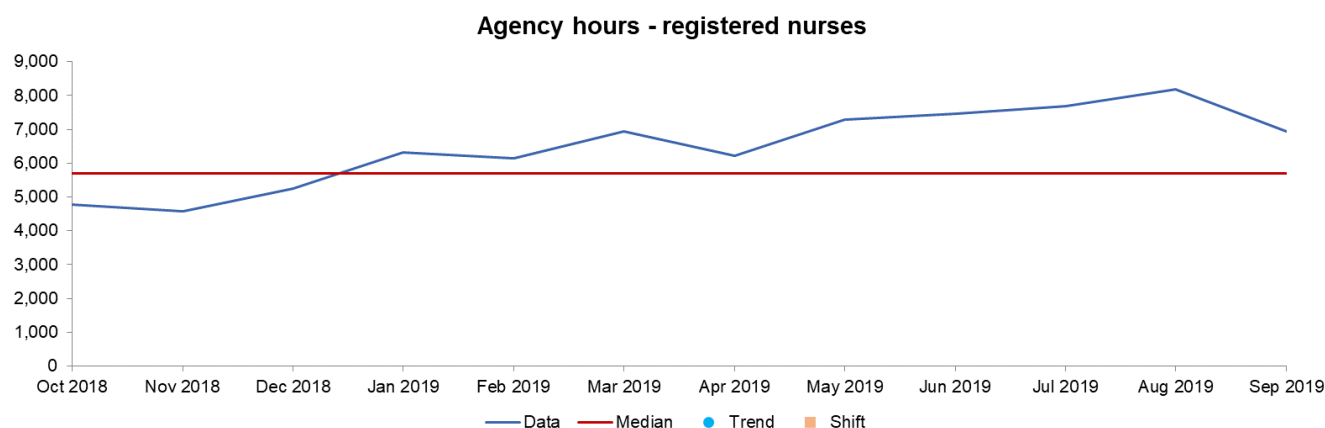
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The service had low rates of bank and agency nurses until August 2019 and the trend began to reduce again towards September 2019.



Monthly bank use over the last 12 months for registered nurses were not stable and may be subject to ongoing change.



Monthly agency use over the last 12 months for registered nurses were not stable and may be subject to ongoing change.

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

Basingstoke and North Hampshire Hospital

The service generally had enough nursing and support staff to keep patients safe. In 2018, staffing levels were noted to be poor. However, by 2019 and on this inspection, staffing levels had improved. There were daily staffing meetings which enabled management to have better oversight of staffing in the department on a daily basis. Staff involved in these meetings known locally as safety huddles, included matrons, consultants and managers of the day. Immediate safety and patient flow issues were raised with trust managers for supportive action to be taken. Staff told us they were able to work bank shifts for additional pay, these were called golden shifts. However, staff told us that staffing levels seemed lower from 4pm as night and evening shifts were harder to fill. Senior staff told us they would fill empty shifts as soon as they were aware of this.

Staffing in the resuscitation area was planned for two qualified nurses and data received from the trust told us that there were always two nurses on each shift. One agency staff nurse had worked in the department many times. Another nurse was skilled in intensive care. Staff told us they felt pressured when there were three sick patients and a medical emergency. However, if the area was busy they could alert the staff in the rapid assessment and treatment area and a nurse would help as a priority.

Staff in the paediatric unit told us the department was staffed by one nurse and a health care assistant with support from the ward when needed. Staff told us they would contact the children's ward and handover the care by telephone. Staff would then take the child to the ward. However, if they were unable to hand over care this way there were times they had to leave a staff member alone or the department empty to take a child to the ward. They would ask staff from streaming to stay with the HCA or in the department until they returned. Staff told us that the risk of lone working in the unit was a concern for them if staff were unable to support from the rest of the department.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

During our inspection, senior staff told us they reviewed staffing throughout the day. They attended a staffing meeting at 11.30am where staffing throughout the trust was discussed. At this meeting, staff were moved to support areas that were short staffed. They told us that occasionally agency staff were booked on other wards that were no longer required and they could request they moved to the emergency department. Staff told us they avoided cancelling training days or management days where possible and shared staff from teams within the department to enable staff to attend.

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at Basingstoke and North Hampshire Hospital compared to the trust's targets, where applicable:

Staff group	Urgent and emergency care annual staffing metrics						
	October 2018 to September 2019						
	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of	Annual agency hours (% of	Annual unfilled hours (% of

					available hours)	available hours)	available hours)
Target		8%	12%	3.5%			
All staff	218	24%	11%	5.4%			
Qualified nurses	103	14%	9%	4.4%	19,274 (11%)	48,104 (27%)	4,354 (2%)

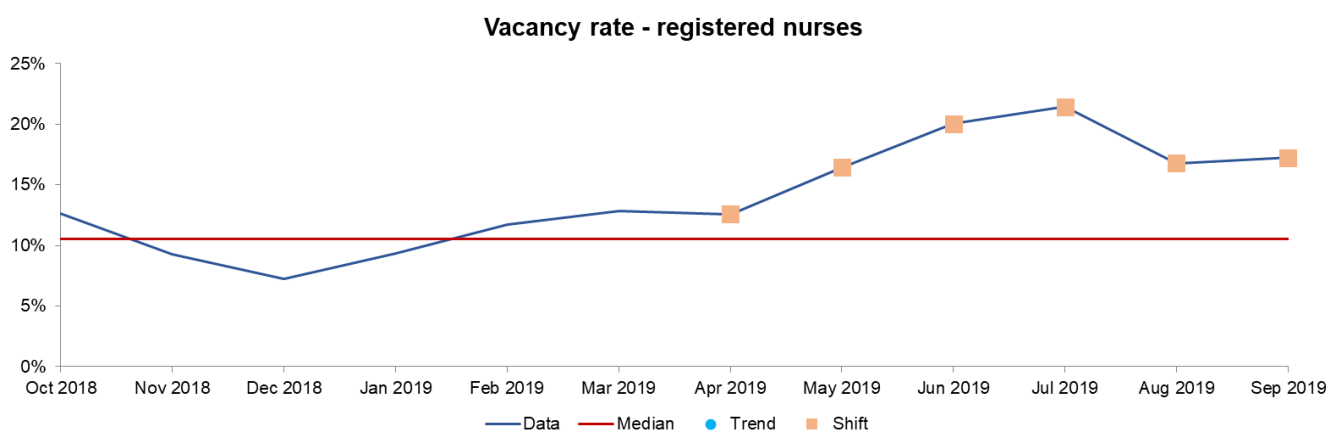
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The ward manager could adjust staffing levels daily according to the needs of patients. Senior staff told us they were able to share staff and support other areas in the department when staffing was low. During this inspection, agency staff were booked in advance to care for patients in the corridor. Senior staff told us that they were able to do this because they already knew the hospital was becoming busy and if they were not required later they could be used to support other teams. Staffing meetings were held in the morning and discussed staffing across the hospital. Often if staff were available they could be used on other wards, the senior nurse in charge on the day would then review the staffing for the rest of the day and book agency if it was still necessary.

The number of nurses and healthcare assistants matched the planned numbers. Senior managers told us that there were vacancies across the department. However, the number of unfilled shifts between October 2018 and September 2019 was 2% which was equal to the trust average. The number of bank shifts used were equal to the trust while agency hours used were slightly higher than the trust for the same period. We were made aware that senior staff would book agency if there was any sign of an increase in patients in the department and were given permission to do so in advance.

Vacancy rates

The service had low vacancy rates but began increasing from April 2019 to September 2019. At the time of this inspection senior staff told us that there were 70 vacancies in the department which may reflect the increase since April 2019. Staff told us the department used bank and agency to support if there were no staff that could cover from other wards.



Monthly vacancy rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019. This could be an indicator of change.

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

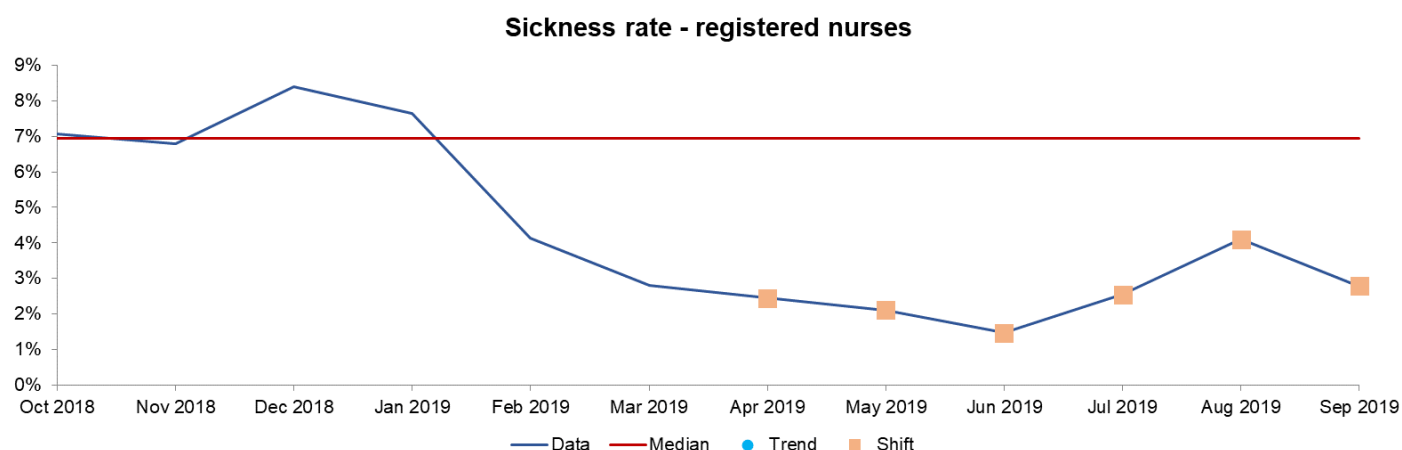
Turnover rates

The service had low turnover rates.

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

Sickness rates

The service had low and reducing sickness rates.

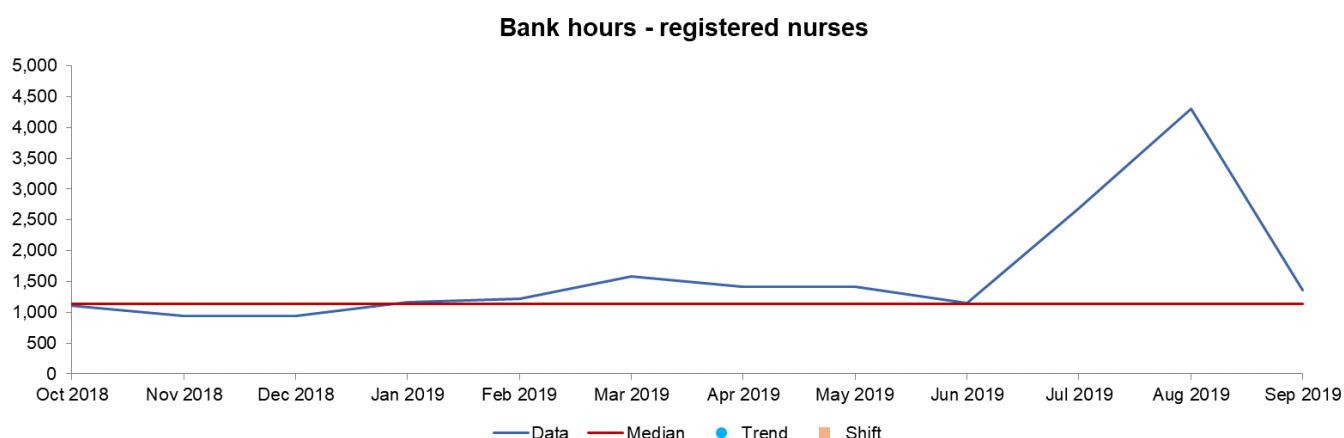


Monthly sickness rates over the last 12 months for registered nurses show a downward shift from April 2019 to September 2019. This could be an indicator of change.

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

Bank and agency staff usage

The service had low rates of bank and agency nurses until August 2019 then reduced again towards the end of September.

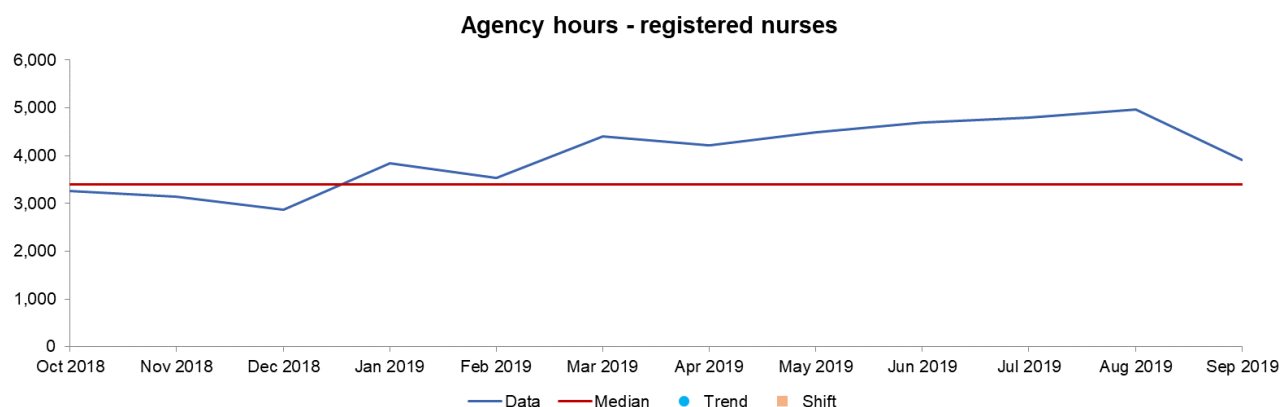


Monthly bank use over the last 12 months for registered nurses were not stable and may be subject to ongoing change. This may have been in relation to the current vacancy rate and approaching winter.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Senior staff told us that they completed a review of agency use every month. The team told us that the trust had a recruitment and retention plan. We spoke to two agency nurses who knew the

hospital and had worked at the trust before. Both told us they enjoyed coming back for shifts when asked.

Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff were given a good induction which included a paper induction booklet. One nurse told us they had worked in several trusts and were returning to the hospital. The staff told us the team were very welcoming. They told us they could also access in-house training. However, they told us they would like to be involved in the major incident training for the department as well.



Monthly agency use over the last 12 months for registered nurses were not stable and may be subject to ongoing change.

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

Medical staffing

The service managed the number of medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Consultants worked at Basingstoke and Winchester sites, covering services in line with Royal College of Emergency Medicine (RCEM) recommendations. However, the senior management team acknowledged there was a significant issue with recruiting middle grade doctors, they told us they were working towards ways of addressing this. In the meantime, staff told us that consultants would cover vacant shifts and locums were only able to work independently when they had been signed off as competent by senior doctors.

Trust level

The table below shows a summary of the medical staffing metrics in urgent and emergency care at trust level compared to the trust's targets, where applicable. The trust informed us that their medical staff at Hampshire Hospitals NHS Foundation Trust have merged workloads across sites. Therefore, the staffing analysis below includes staff working across all sites.

	Urgent and emergency care annual staffing metrics						
	October 2018 to September 2019						
	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (%)	Annual locum hours (%)	Annual unfilled hours (%)
Staff group							

					of available hours)	of available hours)	of available hours)
Target		8%	12%	3.5%			
All staff	432	14%	16%	4.7%			
Medical staff	126	-5%	33%	0.7%	17,861 (15%)	10,847 (9%)	

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

The medical staff did not match the planned number. Staff told us that there was a shortage of middle grade doctors. The service had three consultant vacancies, but the team covered Winchester and Basingstoke sites to mitigate the shortage.

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

Vacancy rates

The service had low and/or reducing vacancy rates for medical staff. However, at 14% this was still above the trust target of 8%.

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

Consultant vacancies were much improved but there were more for middle grade doctors. The team were aware that there was a heavy reliance on agency doctors but they also used bank staff who were well known to the trust and had been used regularly. This meant the bank staff were familiar with the trust processes and were able to work shifts at short notice. The team were looking at a variety of options to improve recruitment including training schemes for overseas doctors, offer GP training in minor injuries and other training roles.

Turnover rates

The service had low and/or reducing turnover rates for medical staff. However, at 16% this was still above the trust target of 12%.

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

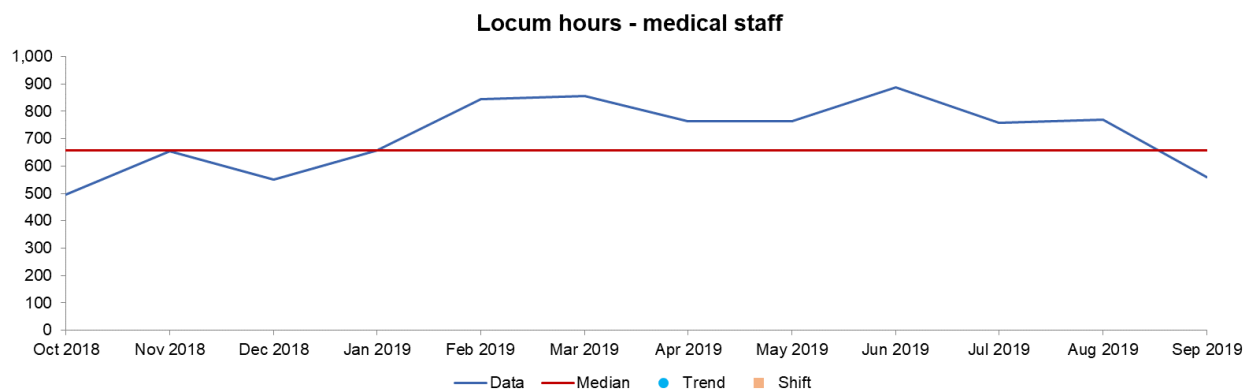
Sickness rates

The service had low and/or reducing sickness rates for medical staff. However, at 4.7% this was still above the trust target of 3.5%.

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

Bank and locum staff usage

The service had low and reducing rates of bank and locum staff.



Monthly agency use over the last 12 months for medical staff show a downward shift from April 2019 to September 2019. This could be an indicator of change.

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

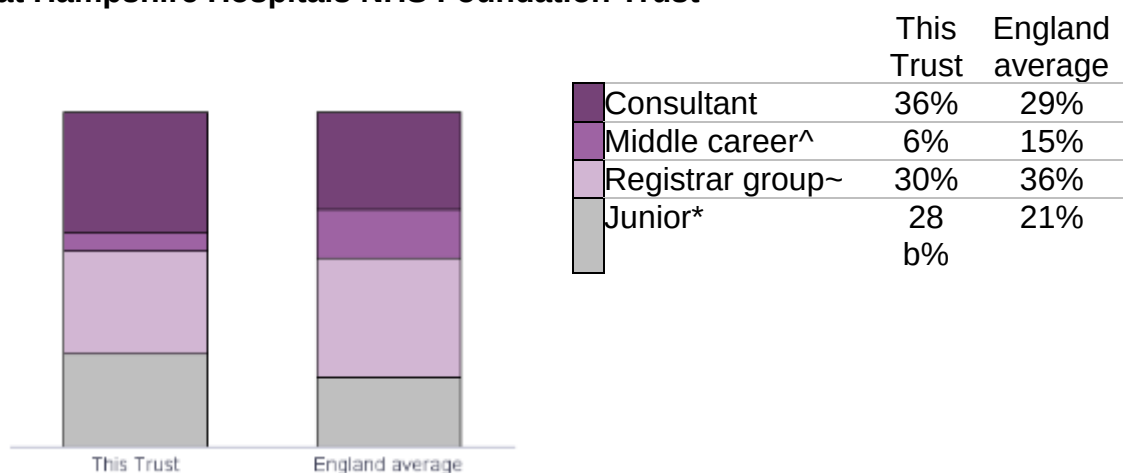
Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly. However, senior staff told us that there were vacancies in middle grade doctors which they were trying to address.

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

Staffing skill mix for the 40 whole time equivalent staff working in urgent and emergency care at Hampshire Hospitals NHS Foundation Trust



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

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

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends. However, the consultants were occasionally required to cover both Basingstoke and Winchester when on call.

Records

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

Patient notes were generally comprehensive and all staff could access them easily. Staff showed us the electronic patient record system. In the emergency department, notes were completed on paper and were scanned onto the system by administrative staff.

We reviewed 11 sets of patient records, four in paediatrics, three in the resuscitation area and four in majors. The notes were all dated and signed with the exception of one in majors. All patient details were completed as were all assessments. The care plans were clear with the evidence of ongoing care noted. Hourly rounds to monitor the patients were completed and recorded. In the resuscitation area and the major's area, the staff maintained the NEWS charts and a sticker with the action required was placed in the patient notes. However, there was no assurance that if the patient continued to deteriorate that the action stickers were used again. This meant that while the NEWS was recorded the action plan was not documented in the same clear manner if patient deteriorated further. We noted that assessments to record if patients were at risk of developing blood clots were not written in four out of the seven notes where patients might have been at risk. This meant that staff were not aware that the patient would need to be monitored for signs and symptoms of blood clots occurring.

When patients transferred to a new team, there were no delays in staff accessing their records. In the department, we noted that the electronic patient record (EPR) was used for basic information such as time the patient arrived in the department and their location. EPR reported if the patient was brought in by ambulance but not if they arrived through the streaming area. Patients that attended themselves had paper records that followed them through the department. The patient name changed colour from red to blue once they had been assessed by the clinician. Other symbols noted how long the patient had been in the department. The patients all had paper records that were taken with the patient if they moved to a ward.

Records were stored securely. Notes were kept in the staff area for patients in the cubicles in majors. Notes for patients in majors two and the corridor were kept in trolleys. We noted that the trolley in the corridor could not be locked but staff were always present. If staff had to leave the corridor trolley unattended, we saw them move it in to majors two where it was with other nurses. However, we did see the trolley in majors two left open and unattended on one occasion whilst the nurse responded to a patient who had fallen.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. During the inspection, we checked on the storage of 15 oxygen cylinders. While 12 were stored securely in solid stands, we noted two standing unsecured in a storage area and one cylinder standing free in a corridor outside bay 10. We raised this with a member of staff who recognised how the cylinders should be stored correctly, and they corrected the problem immediately. All oxygen cylinders were within their expiry date.

We looked at medicines stored in the unit and saw that those in cupboards were within their expiry date and stored appropriately. All medicine cupboards were locked, and the keys kept separately to prevent them being opened by unauthorised staff. We saw daily checks of the contents of the cupboards were completed by nurses in majors and the resuscitation area. Staff in the pharmacy department showed us completed six monthly audits of the controlled drugs in the department and we saw that the register of these medicines in majors and the resuscitation area were also completed. Staff told us that all unused and out of date stock was returned to pharmacy for disposal. We saw that controlled drugs brought into the department by patients were recorded and stored safely. However, we noted that the controlled drugs check was not completed on two occasions in the last month.

We noted that fridge temperatures were monitored and temperatures were within the correct ranges. However, we saw one fridge that contained an open medication bottle that was not dated or labelled. This was raised with the nurse in charge and disposed of immediately. We also saw an insulin pen that had been opened and should have been disposed of within three months. However, the pen was dated as being opened in July 2019. While we noted that most medicines with a limited shelf life were dated with the date they were opened, this showed some inconsistencies in practice for the storage of medicines. We noted that in the paediatric unit the medicine fridges were checked for the correct temperature and dates on medicines. This was recorded daily.

We reviewed the medicines in two resuscitation trolleys in the department. Both contained medicines that were in date and sealed. However, one trolley had medicines in a different drawer. This meant staff might not easily find the medicine they require in an emergency.

We saw grab bags for staff to take to patients were not sealed. We saw bags containing medications for paediatric sepsis, allergies and diabetic emergencies and were not all sealed, with expiry dates or checklists for the contents. If the bags had no tamper evident seal it was impossible to be assured that everything needed in an emergency situation would be found in the box. Without a list of contents and checks on expiry dates staff could not be assured the contents were suitable for use. It was not clear there was a Trust wide procedure for these boxes which should include agreed list of contents, signatures of staff replenishing box and expiry date of box as a minimum.

Some medicines were not prescribed by the doctors in the emergency department if the patient was waiting to be reviewed by a speciality doctor. This meant that patients may not receive their regular medication if they were waiting for a review.

Staff did not always record when they issued a FP10 form. We saw that FP10 forms which are prescription forms that patients were able to take to community pharmacies, were not always recorded when they were issued. We saw that five forms were not recorded between 11 January and 15 January 2020. This meant that there was no record of who had issued the form, what medicines were prescribed and no accurate process to record or monitor medicine related stationary. During the inspection this was raised with the Chief Pharmacist for further discussion.

In the main and paediatric department, we saw that patient group directives (PGD) that allowed staff to prescribe certain medicines were up to date and signed by the correct staff. These were managed by an emergency nurse practitioner. However, we saw that some patient group directives on the trust intranet were not in use and out of date. This meant that there was no assurance that the correct paperwork was available to be used by staff.

We spoke to the pharmacist who was based in the emergency department. They audited incidents related to medicines, missed dosages and sepsis treatment. They told us they had noted that antibiotics had not been prescribed for three patients who were assessed as having symptoms of sepsis in May to July 2019. Information from these audits were shared with the staff and included action plans.

Staff followed current national practice to check patients had the correct medicines. The service had a mixture of paper and electronic prescription processes. In the emergency department, prescriptions were recorded on paper charts. Speciality doctors assessing patients before they were transferred to the ward would upload prescriptions to the trust electronic system. However, this increased the risk of medicines prescribed in the emergency department not being added to the electronic system promptly. This meant patients may not be given those medicines when they were transferred to the ward.

We saw that antibiotics had been prescribed to patients but without a date for them to be stopped. This was not noted to be unusual as patients were not expected to have remained in the department for the full course of antibiotics and their care transferred to a GP or the ward for further treatment. However, it would be appropriate for a review date to be noted as a guide for doctors taking over care of the patient.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We reviewed 11 medicine charts, of which all had the patients allergies recorded. However, none had venous thromboembolism, or deep vein blood clot risk assessment completed. This meant staff were not identifying patients who might be at risk of developing blood clots or ensuring they were prescribed preventative medicines. We also noted that patients who received oxygen therapy did not always have this prescribed.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff told us that they would raise any concerns with the nurse in charge and complete an electronic reporting form.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us they used the online incident reporting system to report incidents.

Never events

The service had no never events in the department.

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

From December 2018 to November 2019, the trust did not report any never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2018 to November 2019.

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

Incident type	Number of incidents	Percentage of total
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	2	28.6%
Treatment delay meeting SI criteria	2	28.6%
Abuse/alleged abuse of child patient by staff	1	14.3%
Slips/trips/falls meeting SI criteria	1	14.3%
VTE meeting SI criteria	1	14.3%
Total	7	100.0%

(Source: Strategic Executive Information System (STEIS))

Basingstoke North Hampshire Hospital

In accordance with the Serious Incident Framework 2015, Basingstoke and North Hampshire Hospital reported five serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2018 to November 2019.

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

Incident type	Number of incidents	Percentage of total
Treatment delay meeting SI criteria	2	40.0%
Abuse/alleged abuse of child patient by staff	1	20.0%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	20.0%
VTE meeting SI criteria	1	20.0%
Grand Total	5	100.0%

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We spoke to three members of staff who were able to explain the duty of candour. They told us how it was important to be open and honest with patients and relatives.

Staff sometimes received feedback from investigation of incidents. At the last inspection in 2018 learning from lessons was limited. In 2019 structured board rounds had been set up and senior staff shared some feedback on incident investigations. On this inspection, we were told by staff that the process for sharing information in team meetings had improved. Staff told us they met in

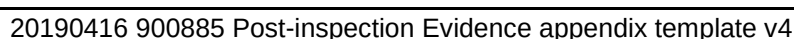
There was evidence that changes had been made as a result of feedback. We saw a large poster of quality improvement projects displayed in the department. This invited staff and visitors to share feedback and ideas for improvements while showing the large number of projects completed in the last year. We saw a board that displayed governance meeting dates and minutes.

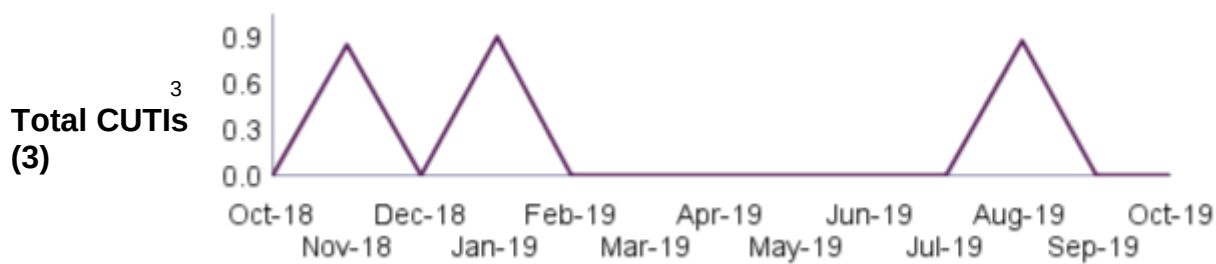
Safety thermometer

Safety data was displayed on wards for staff and patients to see using an electronic board in majors. This information was discussed at the weekly communication call meeting run by senior staff.

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

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





- 1 Pressure ulcers levels 2, 3 and 4
 2 Falls with harm levels 3 to 6
 3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided effective care and treatment based on national guidance and evidence-based practice. Staff followed national guidance to assess, treat and protect patients.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service reviewed compliance with National Institute of Clinical Excellence (NICE) guidance every six months. There was a clinical governance lead who was responsible for reporting on these to the trust and ensuring they were being followed.

Most policies and standard operating procedures were noted to be up to date in both version and review date in both the paediatric unit and the main department. These included diabetic management, tonsillectomy, infant bruising and death of an infant. The frailty team used a nationally recognised frailty tool called the 'Rockwood scale' for identifying frailty. The psychiatric liaison team told us they would follow national guidance when prescribing and reviewing medication. The policy on restraint was out of date but senior staff told us this was being rewritten and was in draft form. This meant that staff were not assured they were reading the most recent policies. However, following the inspection we saw the draft policy which was comprehensive and followed national guidance.

Paediatric staff told us that they were able to access up to date treatment guidelines on line. These included managing fevers, with and without a rash, abdominal pain, head injury, urine infections, diarrhoea and vomiting. There were guidelines on paediatric care on the walls that were in date. In the paediatric unit, the folder containing the policies were colour co-ordinated and on the intranet and were easy to find. These were updated when the unit opened. However, some of the paediatric policies were out of date.

At the last inspection, there were no screening tools used for sepsis and NEWS2. On this inspection we saw the department used a sepsis bundle to assess and treat patients with possible sepsis. We noted that protocols in both areas had improved and working groups had been established to continue this improvement.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff referred patients suspected to be experiencing depression for a mental health assessment. They had introduced triaging forms for vulnerable adults to help screen patients. We observed meetings where the most recent public health

concern, a respiratory virus from Asia, was discussed. We saw information on the virus displayed in staff areas and staff were made aware that they should discuss the patient travel history as part of their initial assessment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The waiting area had vending machines for coffee, snacks, cold drinks, and a water dispenser.

We asked patients if they had been offered food and drink during their stay. All patients asked had been offered food and drink by their nurse and were able to ask for food they liked or preferred. The food offered took account of preferences, both cultural and religious. A relative also commented that they had been offered food and drinks 'which was nice as they could be with their family member'. Patients in the paediatric unit also had drinks available.

Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 6.9 for the question "Were you able to get suitable food or drinks when you were in A&E?". This was the same as other trusts.

(Source: Emergency Department Survey 2019)

Pain relief

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

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw staff asking patients to describe the level of pain they were in and were offered pain relief if they requested it.

Patients received pain relief soon after it was identified they needed it or they requested it. Patients we spoke with told us that their pain was being managed well, and that if they were in discomfort they could always get hold of someone to help relieve their pain.

Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 7.5 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was the same as other trusts.

(Source: Emergency Department Survey 2019)

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff told us that senior staff members took the lead for audits including hand hygiene, record keeping and a NEWS audit. Some took place every month while others were every six months. Staff told us that feedback from audits were shared in a monthly newsletter, in team meetings, or closed online social media groups. This included actions to be taken to improve compliance.

The emergency nurse practitioners completed an audit on x-rays and were auditing the patients who attended the department and fracture clinic. Staff told us there was no formal report of the outcomes from this audit, but staff had individual feedback or feedback during study days.

Staff told us there was a dashboard being developed for the record keeping audit which was completed every six months and every three months for emergency nurse practitioners. At the time of this inspection this was not in use so we were unable to review the new process for recording the audit.

Audits were recorded on an electronic system. However, staff told us the system was difficult to understand and actions plans were limited, staff used a paper action sheet to make recording and completing action plans simpler.

The service participated in relevant national clinical audits. We saw information from the trust reporting that they completed audits for NICE compliance every six months. Staff audited the method and quality of neurology observations and were compliant with NICE guidelines. The trust was developing a sepsis audit in collaboration with the Wessex Regional Sepsis network. The trust had a sepsis lead in both Basingstoke and Winchester hospital sites who attended network meetings. Other audits included antibiotic prescription audits and Royal College of Emergency Medicine audits.

We spoke to the lead consultant for quality improvement and audit. They told us in the last year the focus for audit had been on safety projects linked to patient pathways. Some Royal College of Emergency Medicine audits such as feverish children, thrombolysis (an injection to reduce blood clots) were restarted in 2018-2019. This year the focus was mental health and care of children in the emergency department.

RCEM Audit: Moderate and acute severe asthma 2016/17

Basingstoke and North Hampshire Hospital

The table below summarises Basingstoke and North Hampshire Hospital's performance in the 2016/17 Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics (Audit measures)	Hospital performance	Comparison to other Hospitals	Met national standard?
Standard 1a: O2 should be given on arrival to maintain sats 94-98%.	26.0%	Similar	Not met
Standard 2a:	49.0%	Better	Not met

Vital signs should be measured and recorded on arrival at the emergency department.			
Standard 3: High dose nebulised β 2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department.	18.0%	Similar	Not met
Standard 4: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β 2 agonist bronchodilator therapy.	84.9%	Similar	Not met
Standard 5a: If not already given before arrival to the emergency department, steroids given within 60 minutes of arrival (acute severe).	31.9%	Similar	Not met
Standard 5b: If not already given before arrival to the emergency department, steroids given within four hours of arrival (moderate).	36.5%	Similar	Not met
Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines.	76.2%	Better	Not met

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Basingstoke and North Hampshire Hospital

The table below summarises Basingstoke and North Hampshire Hospital's performance in the 2016/17 Royal College of Emergency Medicine (RCEM) consultant sign-off audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics (Audit measures)	Hospital performance	Comparison to other Hospitals	Met national standard?
Percentage of patients from high-risk groups reviewed by a consultant in Emergency Medicine prior to discharge from the Emergency Department:			
Atraumatic chest pain in patients aged 30 years and over.	Not reported	N/A	N/A
Fever in children under 1 year of age.	Not reported	N/A	N/A
Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge.	18.2%	Similar	Not met
Abdominal pain in patients aged 70 years and over.	Not reported	N/A	N/A

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Basingstoke and North Hampshire Hospital

The table below summarises Basingstoke and North Hampshire Hospital's performance in the 2016/17 Royal College of Emergency Medicine (RCEM) Severe sepsis and septic shock audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics (Audit measures)	Hospital performance	Comparison to other Hospitals	Met national standard?
Standard 1: Respiratory rate, oxygen saturations (SaO ₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival.	20.0%	Worse	Not met
Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED.	82.0%	Better	Not met
Standard 3: O ₂ was initiated to maintain SaO ₂ >94% (unless there is a documented reason not to): Within one hour of arrival.	19.2%	Similar	Not met
Standard 4: Serum lactate measured: Within one hour of arrival.	66.0%	Similar	Not met
Standard 5: Blood cultures obtained: Within one hour of arrival.	32.7%	Similar	Not met
Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival.	28.0%	Similar	Not met
Standard 7: Antibiotics administered: Within one hour of arrival.	36.0%	Similar	Not met
Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival.	36.0%	Similar	Not met

(Source: Royal College of Emergency Medicine)

Trauma Audit and Research Network (TARN)

Basingstoke and North Hampshire Hospital

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

Metrics (Audit measures)	Hospital performance	Audit Rating	Met national standard?
Case Ascertainment (Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)	100+%	Good	Met
Crude median time from arrival to CT scan of the head for patients with traumatic brain injury	66 mins	Takes longer than the TARN	Did not meet

<i>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</i>		aggregate	
Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury <i>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</i>	75.0%	Lower than the TARN aggregate	N/A
Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care <i>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</i>	50.0%	Higher than the TARN aggregate	Did not meet
Risk-adjusted in-hospital survival rate following injury <i>(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</i>	1.3 additional survivors	As expected	Met

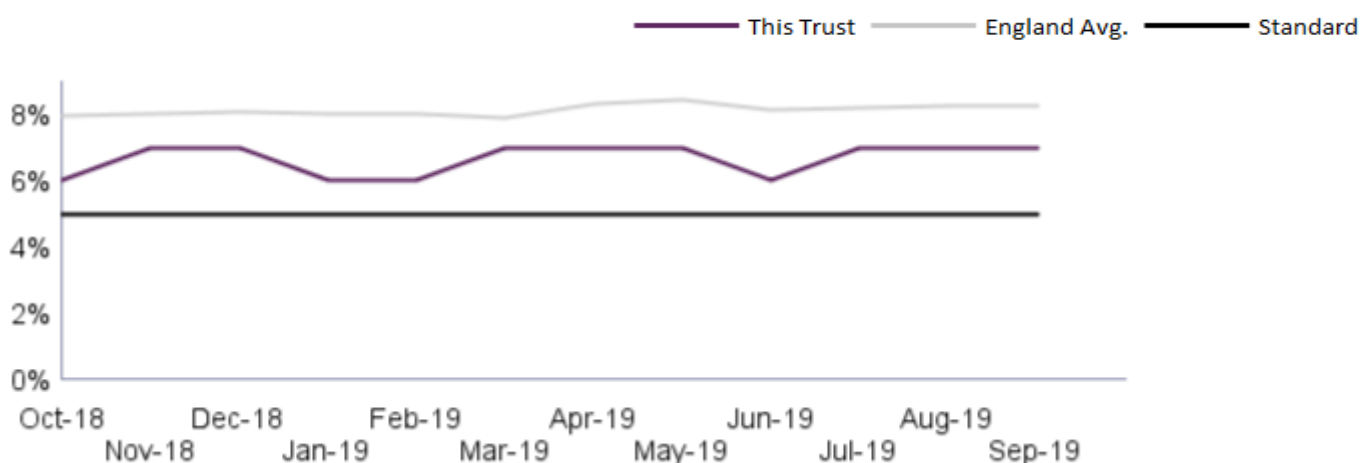
(Source: Trauma Audit and Research Network TARN)

Unplanned re-attendance rate within seven days

The service had a lower than expected risk of re-attendance than the England average.

From October 2018 to September 2019, the trust's unplanned re-attendance rate to A&E within seven days was consistently higher than the national standard of 5% although it was lower (better) than the national aggregate over the same time period.

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



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

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Senior staff told us that there were Friday teaching sessions that focused on education in the emergency department. These sessions included domestic violence, safeguarding, awareness of treating patients who were hard of hearing and included all clinical staff. Staff in the rapid assessment and treatment area told us they had additional training in identifying where to send patients after they had been assessed.

We spoke to three health care assistants who were training as nurse apprentices. They said they were encouraged to complete the apprenticeship and were offered this as soon as they started in the trust. They told us they were well supported in this development and were able to access training from within the trust and from specialist nurses in the emergency department. The apprentices told us they were taking a two-year course with 35 mandatory units and 15 additional ones that included specialist skills such as cannulation. They told us they would achieve a Health and Social care level three qualification. The apprentices used a secure communication app to share learning and practice and any apprentices in the trust were able to join the group.

One newly qualified nurse told us they had completed a medicines booklet as part of their training. They were waiting for a personal identification number so they could start giving medicines to patients once they were prescribed.

Staff told us that they believed the opportunities to have additional training had improved in the last year both in the main department and in the paediatric unit. This training included training in specialist nursing intervention for taking blood, additional skills in paediatric care and learning skills that allowed them to work in other departments. Staff told us they had department training each month with two hours of clinical teaching and one hour to review their progress and competencies. We spoke to non-clinical staff who had requested additional training in their appraisal to allow them to assist staff in taking blood pressures, taking blood and moving patients on beds. They told us they were currently able to help staff by feeding patients and other non-clinical tasks.

New staff told us they were part of a preceptorship programme and they were able to develop additional skills in advanced life support and skills required in emergency medicine during the first year in post. They told us they were given time to study and practice these skills.

Senior nurses told us they attended development days and had access to leadership courses. Senior staff also had monthly peer group meetings.

We spoke to allied health professionals who told us that they rotated between specialities in the trust which allowed them to develop skills in different areas.

We spoke to staff who were training. They told us they had spent two weeks in the department to develop their practical skills and complete a record of the skills learnt. They were very complimentary of the scheme, staff and learning opportunities in the department. They told us they felt very supported by other staff and were quickly accepted as one of the team.

The trust offered a training programme in advance clinical practice for clinical staff. The first staff member at Basingstoke undertaking the training was due to complete the course in March 2020. Middle grade doctors were able to use an induction app on line. This gave them quick access to standard operating procedures for the area they were working in.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us they had been given a full induction before they started work in the department. Nurses told us they had three weeks where they had worked in the department as extra staff. In this time, they had worked alongside paediatric nurses, the mental health liaison team and in the ambulatory care and acute assessment units.

Health care assistants told us they had two weeks where they worked alongside another experienced health care assistant while also training to develop the skills required for working in the emergency department. New staff of all grades were given the opportunity to work as extra staff alongside colleagues when they first started in the department.

Junior doctors were given two shifts alongside consultants before they were signed off as able to work in the department.

All staff had a one-day trust induction and were assigned to a team leader and mentor. Staff told us they had a paper induction booklet they could refer to.

Appraisal rates

As at September 2019, 91.9% of staff within the urgent and emergency care core service at the trust received an appraisal compared to a trust target of 90%.

Trust level

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add prof scientific and technic	1	1	100.0%	90%	Yes
Allied health professionals	1	1	100.0%	90%	Yes
Nursing and midwifery registered	145	153	94.8%	90%	Yes
Administrative and clerical	47	51	92.2%	90%	Yes
Additional clinical services	71	79	89.9%	90%	No
Medical and dental	31	37	83.8%	90%	No
Total	296	322	91.9%	90%	Yes

Basingstoke and North Hampshire Hospital

As at September 2019, 90.8% of staff within the urgent and emergency care core service at Basingstoke and North Hampshire Hospital received an appraisal compared to a trust target of 90%.

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add prof scientific and technic	1	1	100.0%	90%	Yes
Allied health professionals	1	1	100.0%	90%	Yes
Medical and dental	3	3	100.0%	90%	Yes

Nursing and midwifery registered	79	86	91.9%	90%	Yes
Additional clinical services	55	61	90.2%	90%	Yes
Administrative and clerical	28	32	87.5%	90%	No
Total	167	184	90.8%	90%	Yes

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

Managers supported staff to develop through regular, constructive clinical supervision of their work. At this inspection, we were shown that the current appraisal rate for December was 84%. We were told this was because there were seven staff on maternity leave and four on long term sickness leave who were also included in the figures but had had no appraisal as they were not at work. The data we received from the trust before the inspection showed that Basingstoke and North Hampshire Hospital was compliant with the trust target but were not achieving it for administrative staff.

The clinical educators supported the learning and development needs of staff. Staff told us doctors had access to a clinical educator and nurses had a nurse practice educator. Both educators wore polo shirts with either clinical educator or nurse educator on the back. Staff told us that this allowed them to work alongside staff without being called away for clinical work. Senior managers told us they were in the process of employing a Mental Health educator. This postholder was to train and develop staff in working with patients with mental health issues.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. We spoke to staff in the paediatric unit who told us they had a team meeting every two months. Senior staff told us they held a monthly team meeting for the whole department. Minutes from the meetings were emailed to staff that could not attend.

We spoke to administration staff who told us they did not have regular team meetings but that they were invited to debriefings in the department if they had been involved in incidents. However, staff told us they did not feel fully informed of changes in the department.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they used an online tool to monitor their own training. The system allowed them to see when training was completed, due or out of date. Staff told us it was easy to use and helped them to stay up to date and in control of their own training needs.

The seven staff we spoke to told us they had had an appraisal. Most told us that they were able to discuss training needs and found it easy to talk to their managers. We noted that administrative and clerical staff did not meet the 90% target for appraisals. The administration staff we spoke to told us they had received an appraisal within the last year. However, we were told by one member of staff that the appraisal they had was repetitive.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge, alongside any specialist training for their role. Senior staff told us they would review the training for medics at each appraisal. This meant doctors were able to discuss training they would like to have and review their compliance with mandatory training. Nursing staff told us they were able to identify additional training at any time during the year and did not have to wait until their appraisal.

Managers recruited, trained and supported volunteers to support patients in the service. Staff told us there were volunteers who helped in the department. They were often in the department in the

afternoon and wore a green tabard, so they could be identified. However, we were unable to speak to volunteers on this inspection.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw staff from different disciplines working together to assess patients. We spoke to occupational therapists who had received a verbal referral from a doctor to see a patient. They checked the time the patient had been in the department to see if they were about to breach the four-hour target before seeing the patient. This meant the team were able to work alongside the nurses and doctors to monitor the time spent in the department by each patient and prioritise patients that had been waiting longest. Staff told us they worked closely with nurse specialist teams including community services so that patients care was discussed with other health care professionals to plan care and treatment after discharge.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Psychiatric liaison staff told us the emergency department staff were very good at alerting the team to appropriate patients. They told us staff treated patients with respect and the liaison team left care plans in patient records for ongoing care including advice on managing symptoms. Staff were able to give patients information about local services, help lines and support.

Seven-day services

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

Patients are reviewed by specialist consultant team depending on the care pathway seven days a week. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The frailty team worked from 8am to 6pm five days a week but were planning to extend this to a seven-day service. The department was supported at the weekend by two physiotherapists, an occupational therapist and a therapy assistant. The therapy team told us that they also covered in-patient wards at the weekend and could be paged to assess patients in the department. From Monday to Friday, therapists could also be called to the department if required.

The service had arrangements, known to all staff on duty, to meet patients' urgent or emergency mental health care needs at all times, including outside office hours. This included accessing the psychiatric liaison team and local community mental health services.

The emergency department had an X-ray service within the department which was available 24 hours a day seven days a week. Staff told us they were able to book an X-ray online and then the patient would be seen within five to 10 minutes. A radiologist told us that they were available over night and could also be asked to see patients on the ward in that time. Staff also told us that they could access the CT scanning service at any hour of the day or night. Once again, the scan was booked on line and the patient was seen within 30 minutes. Radiology staff would move between both CT and X-ray at night. Magnetic Imaging (MRI) was not available 24 hours a day, seven days a week.

Health promotion

The service gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards/units. We saw information displayed for carer support. However, information displayed was out-of-date. Advertising for the Basingstoke carer support group displayed dates for 2017 and Alzheimer's Society 'singing for your brain', displayed dates for 2018.

In the waiting area, there was a board with alcohol awareness information, which included; where to get advice, effects of alcohol use and what units of alcohol are.

There was a rack with over 40 different leaflets that staff could give to patients upon discharge from the department. The rack had a sign above saying, 'Help break the cycle of reattendance. Don't let your patient leave without clinical care information'. The information leaflets included information on appliance loans, alcohol, discharge instructions, and hospital liaison team for people with learning disabilities. However, we noted there was little health promotion information in the paediatric unit.

We saw a notice board with diabetic information. This included insulin safety, delivery of insulin and storage of insulin. The board also had guidance from The National Institute for Care Excellence; NICE (2016) diabetic foot problems, prevention and management. However, this board was out of date and this guidance was updated in October 2019.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff knew how and when to assess whether a patient had the capacity to make decisions about their care. Staff on the adult side of the emergency department would seek additional advice relating to a patient's capacity to make decisions from senior clinicians if they felt they needed further advice not covered in their mandatory training.

Staff told us they gained consent from patients for their care and treatment and when patients could not give consent, staff made decisions in their best interest. Patients told us that staff asked their consent before completing observations and blood tests. They would discuss the treatment with the patient in order to make sure the patient had the information available to give consent.

However, we did not see that staff clearly and consistently recorded consent in the 11 patients' records we reviewed.

Mental Capacity Act and Deprivation of Liberty training completion

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

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

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	134	170	78.8%	90%	No

In urgent and emergency care the target was not met for MCA/DoLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	52	74	70.3%	90%	No

In urgent and emergency care the target was not met for MCA/DoLS training modules for which medical staff were eligible.

Basingstoke and North Hampshire Hospital

Staff had mandatory Mental Health Act and Mental Capacity Act training. They also had mandatory dementia awareness training. The department had staff that were also qualified mental health nurses and the trust policy was to book an agency registered mental health nurse if the patient was at high risk of self-harm or unmanageable behaviour. However, without this training staff were less skilled to meet the needs of patients while waiting for the agency staff to arrive. Some staff said they did not recall having access to training on mental health awareness.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff in the psychiatric liaison team told us that the staff in the department had a good understanding of the Mental Capacity Act 2005 and would contact the team if they needed advice or support. Staff told us they had training in, and could describe, Mental Capacity Act and Deprivation of Liberty Safeguards when asked and knew how to access policy and get additional advice if they wanted support. However, the training data from the trust showed that the training for nurses and medical staff did not meet the trust target.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Basingstoke and North Hampshire Hospital for qualified nursing staff in urgent and emergency care is shown below.

In urgent and emergency care the target was not met for MCA/DoLS training modules for which qualified nursing staff were eligible. This was lower than the compliance for the nursing staff in the urgent and emergency care across the trust.

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	74	98	75.5%	90%	No

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Basingstoke and North Hampshire Hospital for medical staff in urgent and emergency care is shown below.

In urgent and emergency care the target was not met for MCA/DoLS training modules for which medical staff were eligible. This was also lower than the compliance for the medical staff in the urgent and emergency care across the trust.

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	32	52	61.5%	90%	No

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection, we saw staff interacting with patients. Staff always introduced themselves by name. This meant patients could identify staff who were caring for them. We also saw staff interacting with patients in a friendly manner and regularly checking on their welfare. We saw staff offering extra blankets or food and drink as they walked past patients. We saw a member of nursing staff engaging with a patient, the staff member showed the patient tangled wires from a monitor and said, “Look at my knitting,” to which the patient laughed.

We saw staff assisting patients to dress and moving patients out of the corridor to use the toilet in majors two. Staff were supportive and spoke quietly to reduce the likelihood of the conversation being heard by other patients.

One patient told us they had been in the hospital on many occasions due to a long-term condition. They told us they were always seen quickly due to their condition even when the department was busy. They told us that “Staff work so hard but are always friendly”.

We saw four patients as they were admitted. One was a palliative care patient who was transferred to a side room after a collapse. Their care was monitored and managed with compassion for the patient and family. Staff showed us guidelines on how to manage patients who were dying and how to care for a patient after death. There was a lift to the mortuary within the main department, so patients were not moved along public corridors from the department. This meant that patients were treated with compassion and dignity at all times at the end of their lives.

Patients said staff treated them well and with kindness. During the inspection, we spoke to 10 patients. All patients we spoke with gave us positive feedback about staff. Patients told us that “Nurses have been smashing.” “Nurses are caring and marvellous.” “Staff have been very professional.” “Staff really do care and treat me well.” “Staff are exceptional and caring.” “Staff are

working hard and have the knowledge to their jobs. “We were also told that “Staff are open and honest”.

One patient we spoke to point at two members of staff and told us that ‘these two are great’.

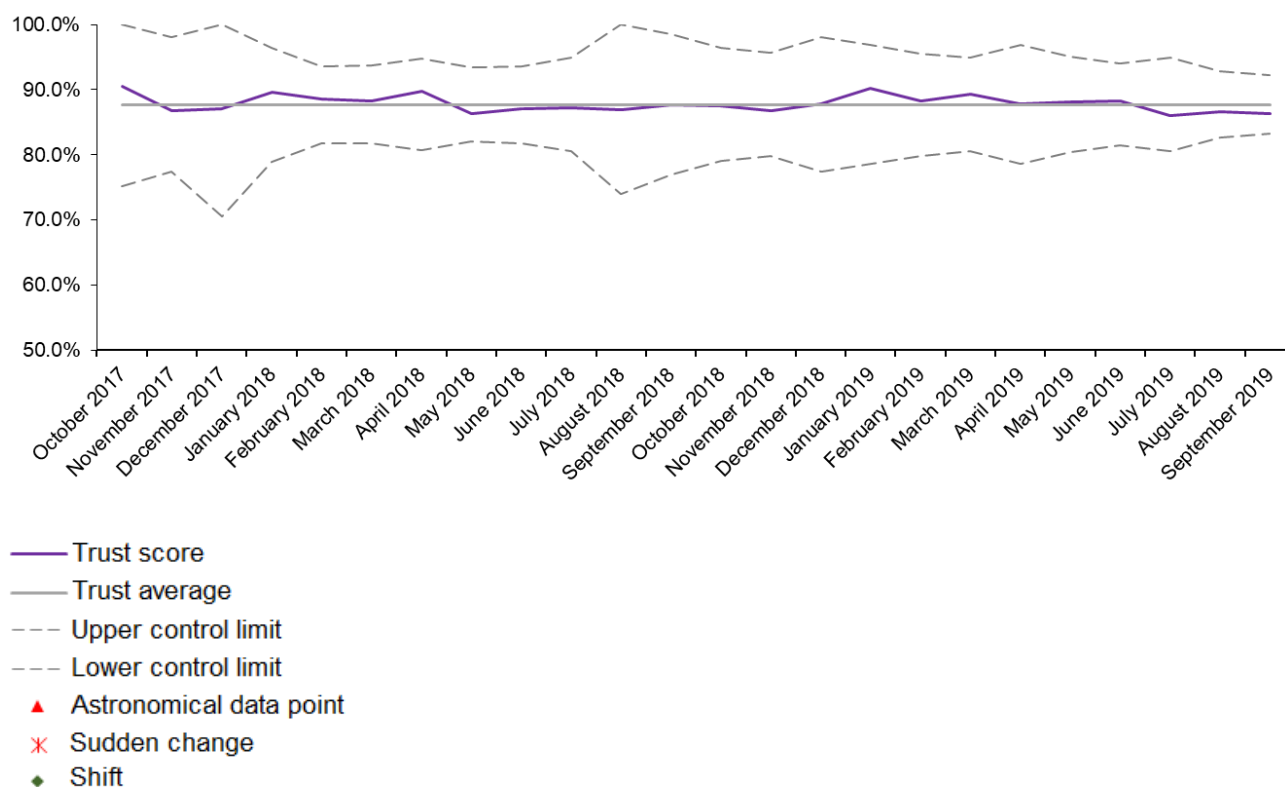
We saw staff transporting the patients through the department and the compassion and care they showed. We observed a patient in discomfort who was being comforted by the staff who were moving them to x-ray. They were compassionate offering the patient encouraging words that they would soon be able to assess what was wrong.

Friends and Family test performance

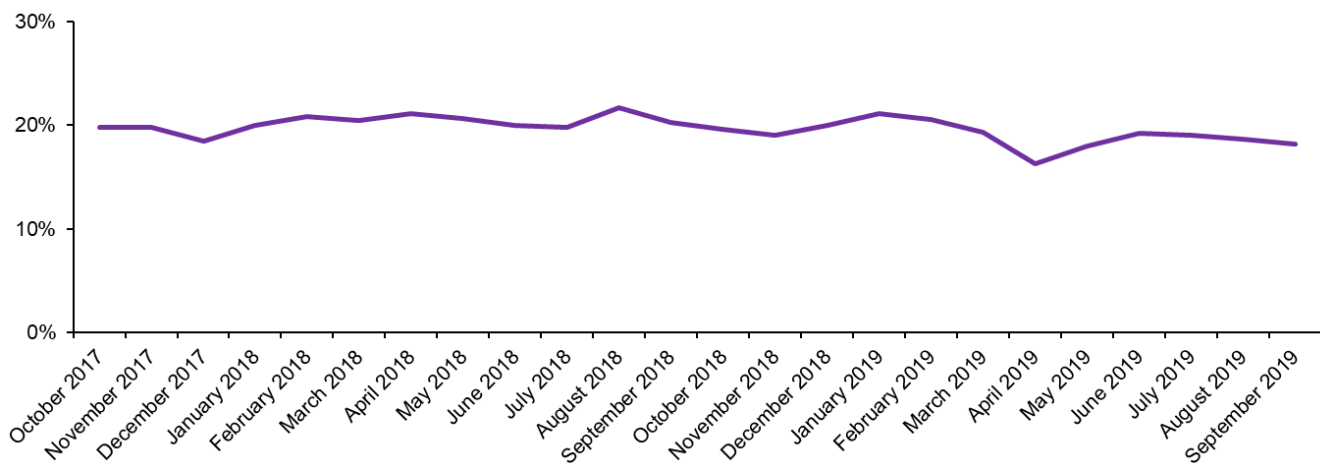
A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. In majors one we saw a notice board displayed the Friends and family test results from November 2019, stating 83% of people would recommend the service. We noted that there was a friends and family box for patients to use in the paediatric unit.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 86.0% and 90.5% from October 2017 to September 2019.

Friends and family test performance – Hampshire hospitals NHS Foundation Trust – October 2017 to September 2019



Hampshire Hospitals NHS Foundation Trust – response rate October 2017 to September 2019



(Source: Friends and Family Test – NHS England)

Staff followed policy to keep patient care and treatment confidential. We saw staff taking patient observations in the waiting area of the department. We discussed this with the matron who explained that the patient had agreed to being assessed there as they were potentially suffering from flu and were to be transferred to a cubicle immediately.

We did not see any signs on doors advising people to knock and wait, which would maintain a patient's privacy and dignity when they were being seen in a room. On one occasion, we saw a member of staff enter an assessment and treatment room without knocking. At the time there were no patients being seen in the room.

On arriving to the department, we saw five patients being treated on trolleys in a corridor. Staff tried to maintain the privacy and dignity of patients being assessed in the corridor with the use of a portable screen. However, the screen did not completely surround the trolley and conversations could be overheard by people passing through the corridor. One patient who was waiting in the corridor told us that "Being in a corridor is not good for privacy; staff are trying their best with screens, but people are in close proximity".

A patient and their relative told us that they had been placed in the corridor at 6pm the previous evening and were still waiting for a bed 17.5 hours later. They told us they understood it was busy and staff were trying their best. The patient told us that they felt tired and had had no sleep the previous night as the corridor was busy with people moving about.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs, learning disabilities, autism or dementia. We observed staff talking to a patient who was confused and was refusing soap and water to wash with. Staff offered alternatives and assisted the patient in cleaning themselves.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The location of the mental health assessment room in majors two was in an area where patients waited for further treatment which could compromise their privacy and dignity. However, staff took action to reduce the impact on the patient by making sure the blinds were drawn and they were supported by a mental health nurse at all times.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us that they had received training in breaking bad news as part of their trust induction. They were able to access additional guidance through the trust intranet. Staff were also able to access the relative's room on the main department where they could sit with relatives or allow relatives to sit. The room was opposite the central nursing station and contained seating and a table.

On this inspection, we were made aware of a patient being brought into the department who was nearing the end of their life. Staff found a quiet room where the patient could be cared for and where family could be with them. This was in line with the Royal College of Emergency Medicine guidelines for care at the end of life. Staff ensured that there was a large butterfly sign placed on the door so that all staff were aware that the patient was dying. The symbol was not recognisable to other patients and therefore the privacy and dignity of the patient and family was maintained.

Staff told us they are able to contact the chaplaincy team 24 hours a day, seven days a week. The service offered support to patients and families of all faiths. The chapel was located on the same level as the emergency department and open all hours.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment and supported patients to make informed decisions about their care. We spoke to a patient who told us they were aware of the plan for their care. Staff asked patients open questions to help make assessments. Staff gave patients an opportunity to ask questions and have input into their care. Most patients were updated when decisions were made. Most patients and relatives we spoke with felt well informed of what was going on with their care, and also believed they had an input into care decisions. However, one patient told us that they felt communication was lacking and they didn't know what was happening next.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients told us that they felt able to raise concerns if they had them. However, no one had felt the need to make a complaint. Patients were able to give positive feedback about the service. We saw 11 comment cards displayed on the wall at the entrance to the department. Patients had said:

- 'The care, time and help was a credit to your hospital'
- 'Massive shout out to ED staff'
- 'Staff were really professional'

Emergency Department Survey 2018 – Type 1 A&E departments

The feedback from the Emergency Department survey test was positive.

The trust scored worse than other trusts for one of the 26 emergency department survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 25 questions.

Question	Trust score	RAG
Q10. Were you informed how long you would have to wait to be examined?	4.1	About the same as other trusts
Q11. While you were waiting, were you able to get help from a member of staff to ask a question?	7.8	About the same as other trusts
Q13. Did you have enough time to discuss your condition with the doctor or nurse?	8.9	About the same as other trusts
Q14. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.6	About the same as other trusts
Q15. Did the doctors and nurses listen to what you had to say?	9.0	About the same as other trusts
Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.9	About the same as other trusts
Q18. Did doctors or nurses talk to each other about you as if you were not there?	9.1	About the same as other trusts
Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?	8.4	About the same as other trusts
Q21. While you were in A&E, how much information about your condition or treatment was given to you?	9.0	Worse than other trusts
Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.1	About the same as other trusts
Q24. Sometimes, a member of staff will say one thing, and another will say something quite different. Did this happen to you?	8.9	About the same as other trusts
Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.2	About the same as other trusts
Q45. Overall, did you feel you were treated with respect and dignity while you were in A&E?	9.0	About the same as other trusts
Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.5	About the same as other trusts
Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.6	About the same as other trusts
Q28. Before you left A&E, did you get the results of your tests?	8.5	About the same as other trusts
Q29. Did a member of staff explain the results of the tests in a way you could understand?	8.8	About the same as other trusts
Q30. If you did not get the results of the tests when you were in A&E, did a member of staff explain how you would receive them?	6.4	About the same as other trusts

Question	Trust score	RAG
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.5	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	5.5	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	6.1	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving A&E?	6.1	About the same as other trusts
Q42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	7.2	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?	8.0	About the same as other trusts
Q44. Did staff give you enough information to help you care for your condition at home?	8.3	Better
Q46. Overall... (please circle a number)	8.2	About the same as other trusts

(Source: Emergency Department Survey 2019)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Facilities and premises were appropriate for the services being delivered. At our last inspection, the layout of the department was not suitable for the number or age of patients attending. There was no separate paediatric area. On this inspection, we saw a new paediatric unit had been built since our last inspection. The unit was open between 10am and 10pm. Staff told us that children had a designated area within the main department outside of those hours. The department was staffed with a registered paediatric nurse and a health care support worker, with support from the paediatric wards on some days.

The emergency department reviewed attendance data to help with service planning. The trust used a system to predict and review the activity over 12 months' to work out how the department might need staffing or extra beds each day. The ambulatory care unit was open Monday to Friday 8am to 6pm. The unit was staffed by nurses and health care support workers with a sister overseeing the unit. We noted that there was an out of hours GP area situated close by where patients could be assessed, treated and discharged without being seen in the main department.

The psychiatric liaison team told us that they found the mental health assessment room appropriate and generally available for use. The department had a room within majors two that

was designed for mental health patients. The room had two doors with windows and blinds on the outside of the door for privacy. There were no ligature points, a strip alarm for staff and patients to call for help and furniture that could be removed if required. However, the team told us that they would like to have more rooms to interview patients as sometimes the mental health assessment room was in use as a quiet room for other patients and staff.

Staff told us they used the relative's room as an assessment room for patients with mental health needs when the main assessment room was in use. This room did not meet national guidance specifications from the Royal College of Psychiatrists. The room had a thick door that could be barricaded, with no viewing windows and it did not have an alarm for staff to summon help if needed. However, senior staff told us they risk assessed the room if it was to be used for patients with mental health needs and if it was not thought to be appropriate they would manage the patient in another way.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The department had access to a psychiatric liaison team who were able to attend the department within four hours. The team had an office in the department, so they were able to respond earlier, at times. Staff told us there was a dementia liaison team but that this was only available during the day and not out of hours. The psychiatric liaison team told us they often worked alongside the alcohol liaison team in assessing patients with mental health issues. However, they told us the alcohol liaison team did not work out of hours or in the evenings where the team needed more support with patients detoxing.

The trust provided information on how staff could make wards and units, such as the emergency department, become learning disability friendly environments. The trust was working with the local clinical commissioning group to meet the learning disability improvement standards for NHS trusts set by NHS Improvement (2018) and highlighted in the Mencap (2018) Treat Me Well campaign. This was a pilot and the results were not yet available. Staff were able to access support from the hospital's learning disabilities liaison nurse.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff in the paediatric unit told us that they were able to refer patients to an external specialist children's own home assessment team. This was funded by the clinical commissioning group and was run by a community paediatric nurse. The service gave care and support to patients and their family in the child's home. The service was available from 8am to 8pm Monday to Friday but the team was able to accept referrals over the weekend. The home assessment team supported patients with tonsillitis, bronchitis and croup, chest infections and gastroenteritis.

Staff told us they could contact a play specialist from Monday to Friday. This staff member was based on the paediatric ward. They told us that the specialist could be called when they were needed and staff from the ward would also support the unit during the week. However, the team told us they would like more cover as the support was very useful when the unit was busy.

We noted that children in the paediatric unit were able to play with toys in the waiting area and staff told us there was a distraction box available for very young patients. Older children were able to use an iPad. There was a television available to also occupy patients waiting.

Staff told us that a domestic violence advocate service was available between 8.30am and 4.30pm, Monday to Friday. Staff were able to refer out of hours by getting consent from the patient and completing a form that was collected the next working day. The advocate had completed training with staff on how to discuss and recognise signs of domestic violence. Staff told us there was a community 'Dragonfly project', where staff were trained to signpost victims to support

services. Staff would wear a dragonfly badge, so they could be identified easily. Patients were able to scan a bar code into their mobile phone which revealed contacts for advice and support.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had access to a mental health liaison team 24 hours a day, seven days a week for adults. However, there was no similar service available for children and young people. Staff told us they had to call children and adolescent mental health team in the community to assess patients. Staff reported that they completed a triage form and then emailed a referral form to the community team. Referral forms included a deliberate self-harm form. Patients who had been referred were then transferred to the children's ward to await assessment.

For patients with dementia, staff told us that they would place a sunflower sticker on the notes to alert staff that the patient may be confused or distressed. It also meant staff knew that the patient could require additional support during their time in the department. Staff told us there were twiddle muffs available to distract and occupy patients with dementia. We saw the notes for one patient brought to the department. The notes reported they had a history of dementia but there was no 'This is me' passport or care plan. This meant that the team did not have an immediate record of the patient's preferences or needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The reception area on the department had a hearing loop for those using hearing aids. Staff were aware of this system and how to share this with patients.

Ambulance staff reported to staff that a patient had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order but the paperwork was not present. We were not clear if the patient had not brought the paperwork with them or did not have them in place. Staff told us in similar cases they would treat the patient as clinically required and then discuss Do Not Attempt Cardio Pulmonary Resuscitation orders once it was appropriate. The clinical decision to treat or not treat patients under these circumstances lay with the senior doctor on duty.

Staff told us they recognised that discussions about organ donation were not a regular occurrence. They told us that this was to be incorporated into the guidelines for the care of the patient after death following the change in national policy due in April 2020. This states that patients and families opt out of organ donation instead of agreeing to it in advance. Staff were able to attend teaching sessions on palliative care and the palliative care team were called as soon as a patient was noted to be approaching the end of life. This meant that both staff and family had access to support in caring for the patient. Senior staff told us they were also involved in the end of life strategy group and were investigating how staff could be trained to manage medications for this patient group.

The service had no information leaflets available in other languages or print sizes displayed in the department. This meant that patients with limited English or had visual impairments were unable to take easily readable information home from the department. However, managers made sure staff, patients, loved ones and carers could get help from translators or signers when needed.

Reception staff were aware of a language line to help translate for patients where English was not their preferred language. Staff told us that many staff members had second languages and that they did not encourage the use of relatives as translators unless there was no-one immediately present. Staff would access the language line to book a translator in person. The trust website also had links to large print leaflets for patients with visual impairments.

There was a poster displaying nursing uniforms. Staff wore 'My name is ... ' badges so patients and relatives could see the names of staff. This was a national initiative and gave patients a way of identifying those who were caring for them.

Staff told us that doctors would request a nurse be present in the cubicle and would ask the patient permission for a chaperone to be present. However, we saw no information at reception or on doors advertising chaperones were available. Staff told us that there had been a sign on the reception desk, but this was now missing.

Emergency Department Survey 2018 – Type 1 A&E departments

The trust scored about the same as other trusts other trusts for the three emergency department survey questions relevant to the responsive domain.

Question – Responsive	Trust score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.0	About the same as other trusts
Q12. Overall, how long did your visit to A&E last?	7.3	About the same as other trusts
Q22. Were you given enough privacy when being examined or treated?	9.1	About the same as other trusts

(Source: Emergency Department Survey 2019)

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Median time from arrival to treatment (all patients)

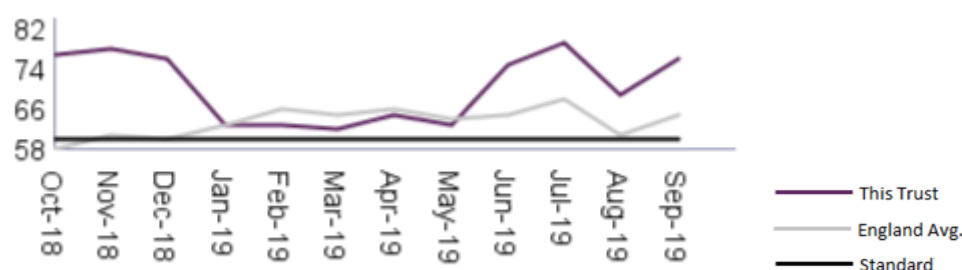
We found that staff in the emergency department had worked extremely hard to improve their working practices to meet the demand and had achieved a great deal. Patients had access to the appropriate service and received, or were directed to, the right care. Flow of patients through the wider healthcare system affected the emergency department and this was reflected in the wait times data.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. There was no visible waiting time displayed in the main waiting area. Administration staff told us that they would tell patients waiting in the reception area of an estimated time to be seen. However, they felt frustrated with the process, as patients would become annoyed with them. The reception area had been redesigned with an initial assessment area.

On this inspection, we saw staff responding to pre-alerts where the team received advance warning of patients who were very unwell. A red telephone was situated in the office in the main department. We saw doctors and nurses answering it and planning for the patient arrival.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for any months over the 12-month period from October 2018 to September 2019. The trust's median time to treatment was especially lengthy compared with England between October 2018 and December 2018 and between June 2019 and September 2019.

Median time from arrival to treatment from October 2018 to September 2019 at Hampshire Hospitals NHS Foundation Trust



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

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

Managers and staff worked to make sure patients did not stay longer than they needed to. During this inspection, we saw the electronic system that tracked the how long each patient was in the department. Each name had a symbol that alerted staff when the patient had been in the department for two hours, three hours, close to breaching at four hours, breaching the four-hour target, six hours and longer than six hours. Each symbol was easily recognised by staff. Patients names changed colour from blue to red and black as they were seen by clinicians. This meant staff were able to identify patient progress through the department at one glance. Staff told us patients moved from the emergency department to the ambulatory care unit remained under the care of the emergency department team. However, patients transferred to the acute assessment unit were looked after by the medical team and were no longer cared for under the four-hour target. Patients seen in the emergency decision unit, within the department, were low risk patients who were expected to go home the same day. Staff told us that patients in the emergency decision unit were only moved there after agreement from the senior nurse and doctor in charge.

Delays for patients in the emergency department were often caused by wider hospital flow issues. We looked at what caused the delays for patients and saw multiple causes influenced the delays. Some were caused by delays in accessing in-patient beds. During the inspection we noted that reasons for patients being delayed was caused by waiting for medical beds.

We attended hospital bed meetings chaired by the director of the day. The meeting involved ward staff verbally reporting on the number of potential discharges for each ward. At the first meeting we attended, ward staff reported a number of empty beds were available but there appeared to be no drive to take patients from the emergency department as a priority even though the department was very busy. There was not always an action plan to deliver more beds and there did not seem

to be efficient use of the discharge lounge. At the next meeting, we saw staff arriving late and holding other conversations. This meant that staff did not appear to give their full attention to the meeting and were not necessarily able to provide up to date information on their bed capacity when asked. The impact could be that beds were not identified to allow patients to be transferred quickly out of the emergency department to the wards.

The trust used operational escalation level ratings (OPEL) to identify how busy the department was. This was colour coded from green which was normal business, amber, red and black when the trust was exceptionally busy. We saw a chart that explained that each level had an action plan and when that should be put in place. Staff told us that if the department became busier than usual and the trust declared an operational escalation level rating of black, additional handovers were held.

We saw a bed meeting, with the operational escalation level rating at black, chaired by a consultant at 9am. Risks were identified with actions to manage them and the next meeting time was agreed for 11am. Senior staff told us that at this meeting extra nurses could be requested and staff from the emergency decision unit would support them. All patients were seen by the doctors and those that could be monitored in the corridor until they were discharged or transferred to a ward were moved out of cubicles. Staff told us that all patients identified had to be appropriate to move and had a repeat of their NEWS2 score. Staff were also able to request additional porters to support the general assistants in moving patients.

We saw an 11am meeting where the beds available were still under pressure but the operational escalation level rating had been changed to red. All patients were discussed again including those in the paediatric unit. The team discussed moving a palliative care patient out of the resuscitation area to a quieter cubicle as there was no bed available on the ward. This was done before the next meeting. The team also considered the option of diverting ambulances to Winchester if necessary. Another meeting was set for 1.45pm. Due to a minor influx we noted that the operational escalation level had returned to black by the afternoon. Extra staff were booked for the evening and the next morning to manage any potential increase in patients overnight. Ambulances were not diverted as the team were able to manage the transfer of patients to other areas within the hospital.

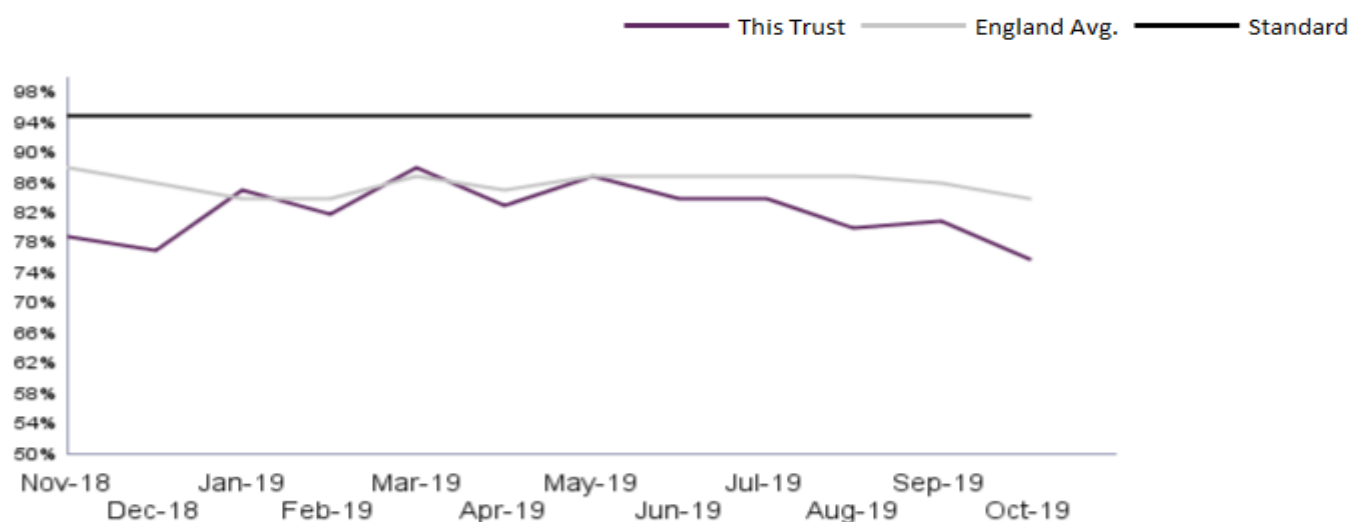
Staff told us that when the department was exceptionally busy out of hours and overnight, the team would alert the site management team and on-call hospital managers. On call consultants were called in to support the department. We saw that the level changed automatically on the ED electronic board. Staff used 'reverse queueing'. Patients would wait in the 'Fit to Sit' area in majors two and would be moved into the department when a cubicle was available. Any patients waiting for outcomes or treatment, and considered low risk, were moved back to majors two. All patients were risk assessed to make sure this was safe for their care.

Following the inspection, we received the trust policy for managing overcrowding in the department. On this inspection the department was busy with an operational escalation level rating of black at times, but the policy was not fully implemented. We saw elements of the plan for example the management of patients being treated and assessed in the corridor. We observed that the policy was followed in these cases. Patients had pressure mattresses and were looked after by two members of staff. Patients in this area were clinically stable and waiting transfer to a ward or discharge.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From November 2018 to October 2019 the trust failed to meet the standard and overall performed worse than the England average with performance worsening particularly from June 2019 onwards.

Four-hour target performance - Hampshire Hospitals NHS Foundation Trust

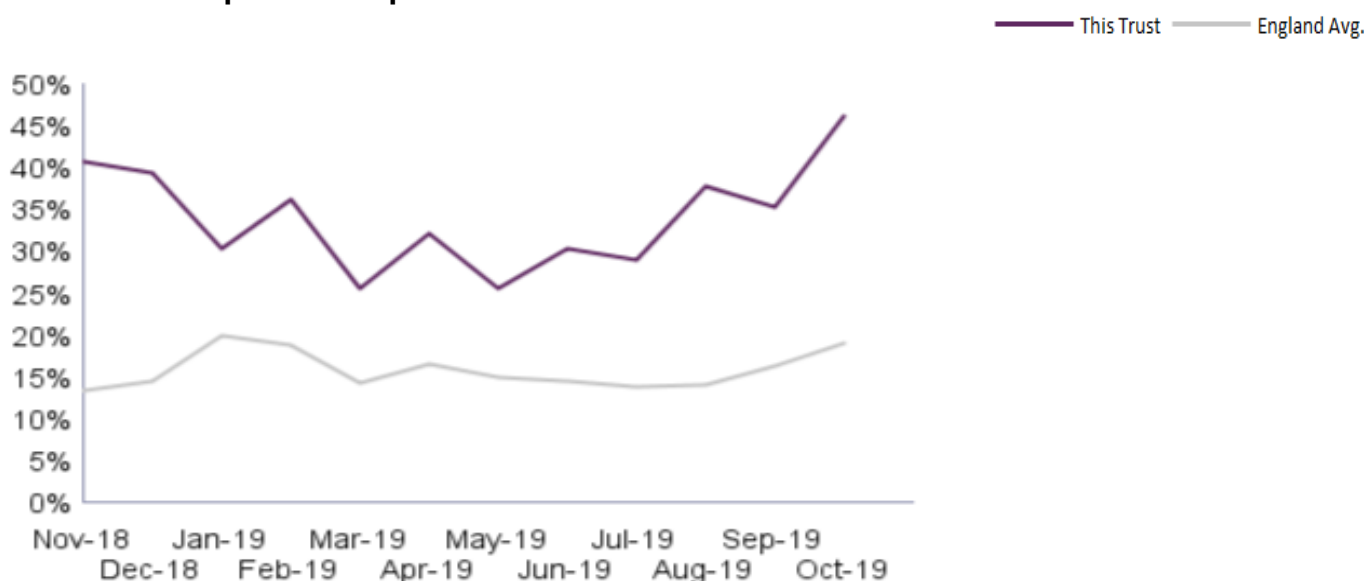


(Source: NHS England - A&E Waiting times)

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

From November 2018 to October 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

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



(Source: NHS England - A&E SitReps)

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from November 2018 to October 2019, 29 patients waited more than 12 hours from the decision to admit until being admitted. The months with the highest number of patients waiting over 12 hours were November 2018, February 2019, April 2019 and October 2019.

Month	Number of patients waiting more than four hours to admission	Number of patients waiting more than 12 hours to admission
Nov-18	1,105	5
Dec-18	1,032	0
Jan-19	830	0
Feb-19	914	5
Mar-19	745	1
Apr-19	1,008	5
May-19	817	1
Jun-19	942	1
Jul-19	920	0
Aug-19	1,133	3
Sep-19	1,098	1
Oct-19	1,550	7

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

Following the inspection, the trust showed us data that all patients waiting for more than 12 hours to admission were patients awaiting mental health beds. We requested information on patients who had been in the department for over 12 hours while waiting support from mental health teams. The trust told us about two patients that had waited 13 hours and 22 hours from being assessed by the mental health team to being transferred to inpatient mental health units. Both patients had been appropriately assessed, a risk assessment completed and one to one supervision provided. All of the cases had been discussed with local services to share the outcome and begin to learn from the delays and the impact on the patients. Senior staff told us that the local mental health service was addressing the number of beds available to try to resolve this.

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

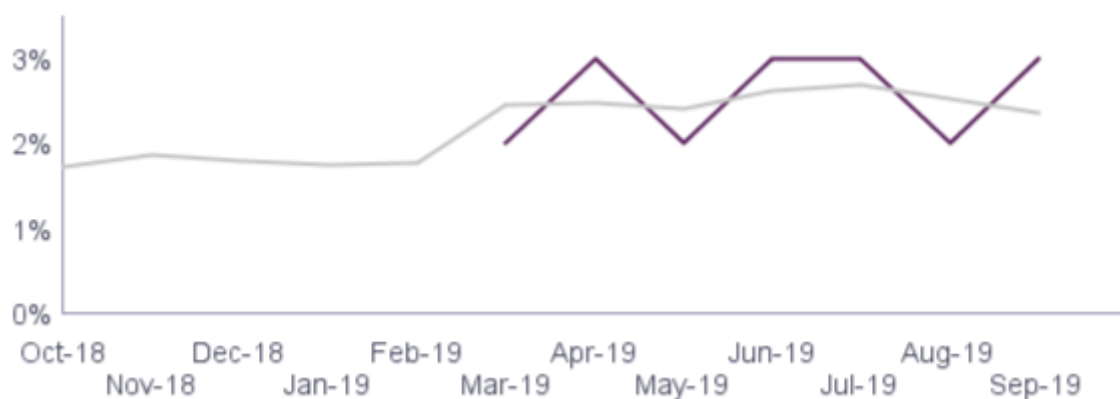
The number of patients leaving the service before being seen for treatments was similar to the national average.

The analysis below is based on the seven-month period from March to September 2019.

From March to September 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was largely in line with the England average.

Percentage of patient that left the trust's urgent and emergency care services without being seen - Hampshire Hospitals NHS Foundation Trust

— This Trust — England Avg.



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

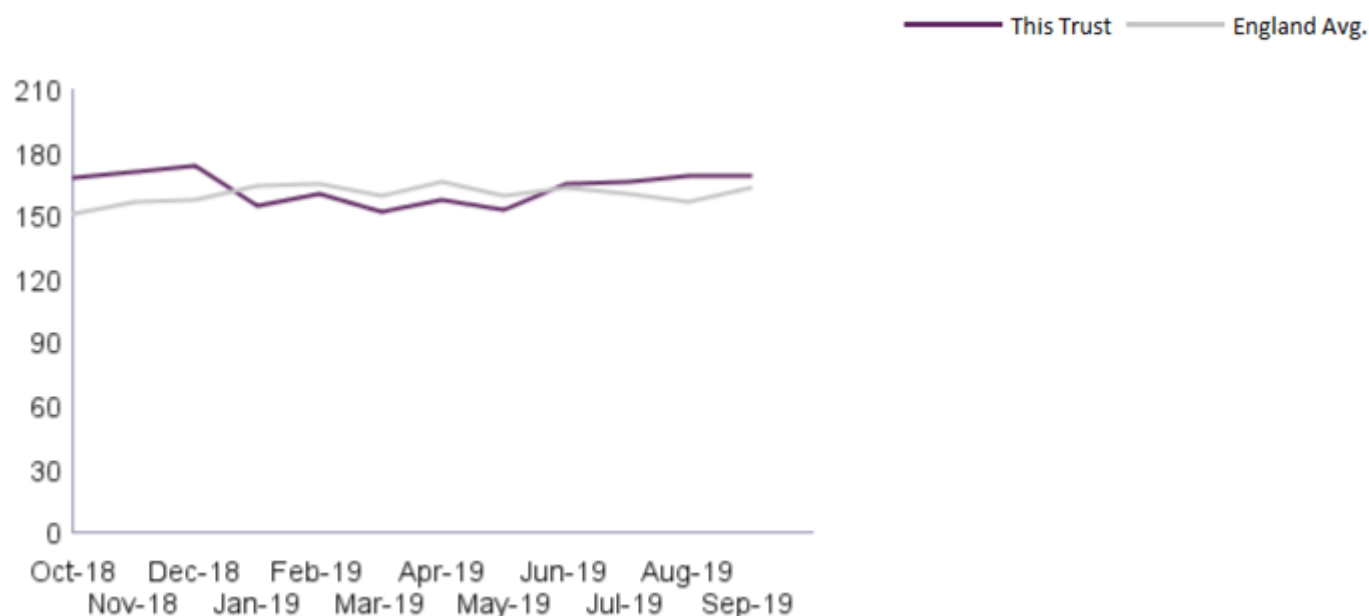
Following the inspection, the trust shared data that showed that the number of patients leaving without being seen was lower at Basingstoke than the trust, but this remained higher than the England average.

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

From October 2018 to September 2019 the trust's monthly median total time in A&E for all patients was higher than the England average for seven out of 12 months.

Over the whole period total time spend in A&E at the trust ranged from 152 to 174 minutes, against an England average ranging from 151 to 166 minutes.

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



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

Managers and staff worked to make sure that they started discharge planning as early as possible. The trust told us that consultants and middle grade doctors followed the same discharge planning process on all sites which made this consistent. The trust had a frailty team who would start assessment of patients as soon as they arrived in the department. Patients were identified as frail using a nationally recognised tool which considered age, diagnosis, medical history and social

support. Staff told us that the team included a nurse practitioner who was able to prescribe medication, a matron, mental health nurse, consultant geriatrician and an administrator. They told us there was an occupational therapist due to join the team in the next month but the team was supported by the occupational therapy team until then. The team accepted referrals from staff in the department in person or by phone. The administrator was able to see the ambulance screen showing patients on their way to the department and could alert the team. Staff told us that the team could also see patients that they identified themselves as they were admitted.

Staff in the team told us that they started their discharge assessment alongside the clinical assessment in the emergency department. The assessment included checking how the patient managed at home and the support they had. If the team decided that it was not safe for the patient to be discharged the same day, they would discuss it with the doctors in the department and arrange a transfer to a ward or short stay ward. Staff told us they felt supported in decision making and that their opinions were valued and listened to by the rest of the team. We saw a consultant doctor making a verbal referral to the team, requesting and listening to their opinion and discussing the plan for discharge.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The psychiatric liaison team told us they would book patients an appointment with the adult mental health team on discharge or refer them for a community assessment. Alternatively, the team would advise an overnight admission until the care was available to support the patient.

Staff supported patients when they were referred or transferred between services. The department employed general assistants who transferred patients to x-ray, CT scanning, and other units. If the team were unavailable staff could call the porters who were available at all times.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We saw patient information leaflets in the department on how to contact the patient liaison services (PALS) or the complaints team.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us they knew how to manage concerns from a patient and how to discuss their complaint. We spoke to six staff members who told us that they knew how to manage complaints in the department. All the staff we spoke to told us they would try to manage the complaint and then discuss with the nurse in charge or doctor if it related to patient care. Staff would document when they had explained the care being given and would discuss with the patient or carer how to contact patient liaison services (PALS) or the complaints team.

Managers investigated complaints and identified themes. Staff told us they were made aware of complaints and any themes as part of team meetings. Following the inspection, we saw minutes that showed complaints were discussed.

Summary of complaints

Trust level

From October 2018 to September 2019 the trust received 130 complaints in relation to urgent and emergency care (17% of total complaints received by the trust). The trust took an average of 20.0 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be investigated and closed within 25 working days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	48	36.9%
Communication	18	13.8%
Values and behaviour	17	13.1%
Patient care	13	10.0%
Admissions and discharges	9	6.9%
Waiting times	7	5.4%
Trust admin/policies/procedures	6	4.6%
Other	3	2.3%
PDW	3	2.3%
Facilities	2	1.5%
Appointments	1	0.8%
Staff numbers	1	0.8%
Consent	1	0.8%
Access to treatment and drugs	1	0.8%
Total	130	100.0%

Basingstoke and North Hampshire Hospital

From October 2018 to September 2019 there were 77 complaints about urgent and emergency care at Basingstoke and North Hampshire Hospital.

The hospital took an average of 18.9 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be investigated and closed within 25 days. A breakdown of complaints by type is below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	30	39.0%
Communication	12	15.6%
Patient care	8	10.4%
Values and behaviour	8	10.4%
Waiting times	6	7.8%
Trust admin/policies/procedures	4	5.2%
PDW	2	2.6%
Other	2	2.6%

Admissions and discharges	2	2.6%
Facilities	1	1.3%
Consent	1	1.3%
Staff numbers	1	1.3%
Total	77	100.0%

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they had feedback when the complaint related to the department, team or individual. Feedback was face to face or in team meetings. On this inspection, we saw a large poster in the department that told patients and staff how feedback was acted upon. New projects included mental health rooms as safe spaces for distressed patients and an improved paediatric unit.

Number of compliments made to the trust

From October 2018 to September 2019 there were 66 compliments about urgent and emergency care at the trust. A breakdown of compliments by site is below.

Site	Number of compliments	Percentage of total
Royal Hampshire County Hospital	33	50.0%
Basingstoke and North Hampshire Hospital	31	47.0%
Andover War Memorial Hospital	2	3.0%
Total	66	100.0%

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

Is the service well-led?

Leadership

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

During this inspection, we met several senior managers and clinicians. Department leadership was very cohesive and enthusiastic. Staff told us that they found the management team very approachable and communication with the department was very good. Staff told us that they were supported by the clinical and medical director and that the matron was very visible in the department.

The divisional team were newly formed in the last year and they expressed enthusiasm and pride in their teams. We discussed challenges to the service and the achievements in the last year and since the last inspection. We noted that the team were passionate about working together to improve the department and eager to share those improvements with staff and the public. We saw a large poster in the department recording over 60 projects or improvements completed since September 2018. Some were projects to develop clinical education for staff, new guidelines for treatments, others were developing a maternity resuscitation trolley, building a new rapid

assessment and treatment bay and paediatric unit. Projects also included developing paediatric mental health assessment paperwork and a working group for early warning scores.

One senior manager told us that although the trust medical director was not in the department often they were very supportive and approachable. They acknowledged that staff were unlikely to know trust management by sight but that the support they gave was appropriate. We spoke to staff who agreed with this. Staff told us that the senior nurse would help in the department when it was extremely busy. The head of unscheduled care was in the department daily.

Vision and strategy

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

Senior staff told us the service was about to start developing the strategy for the next five years. Staff told us that they were aware of the trust values but not the vision or strategy. This was acknowledged by the senior team who had used a quiz to see how much staff knew about the current vision and strategy and found staff only knew the values. They told us they were planning a series of sessions with staff as part of developing the new strategy and would involve staff in writing it. Once a draft had been written the team planned to share it for comments and discussion in team meetings.

The management team told us they understood that the ownership of flow of patients from the department to the rest of the hospital was not always good. They told us that it often seemed that the department was pushing for available beds while the rest of the hospital were not always offering beds first. They told us that the all the department staff believe that caring for patients in the corridor is unacceptable, work hard to manage care in the corridor and make sure this is not considered to be normal.

The team told us they felt there was an effort being made to improve processes but that it was not always noticeable in the emergency department. We were told that there was work being done to address this with the local care commissioning groups which included pathways so patients could be admitted straight to the ward rather than being seen in the emergency department first.

The service had a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually. The trust board included a clinical lead responsible for the mental health strategy and developing clear, measurable health outcomes.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that they enjoyed having contact with patients and working in the department. They were flexible in regard to supporting each other and teams within the emergency department. One member of staff told us they felt very supported as this was their first nursing job and they were thoroughly enjoying it. Every member of staff we spoke to told us they 'loved' working in the trust

and department. Two members of staff had been working there for several years and would recommend the trust for people to work and for their family to be treated.

Staff told us that they were well supported by management in the department. Staff told us that they could talk to managers about personal issues and that they were supported in adjusting their working hours if necessary. Staff told us this was done within days even if the rota had to be changed. We saw team meeting minutes where staff well-being was discussed. We saw that there was a wellbeing lead and a service where staff could access support and advice.

Staff told us they were able to report incidents using the online reporting system and were comfortable doing so without fear of being blamed. Staff told us they were able to share learning from incidents as peers and through team meetings. Staff we spoke to knew how to contact the freedom to speak up guardian and knew they had attended the department to talk to staff. We saw posters in the department and, although staff told us they knew how to access support they had not needed to.

However, reception staff told us they felt that other staff did not understand their role and how busy they could become.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Senior staff told us they held fortnightly department governance meetings which linked to the divisional governance meetings. We saw minutes that were comprehensive and included discussions on training, safeguarding, incident reporting, staffing, complaints and compliments. The meeting also included quality improvement, infection control and the service risk register with actions plans and a date for review.

We attended the weekly communication cell meeting run by senior staff in the department. This was held in the main department and all staff were able to attend for all or part of the meeting. Staff were told the latest figures for the number of patients attending the department, the percentage of patients seen within 15 minutes of attending the department and the number seen within four hours compared to national targets. The staff were also told about the number of patients who self-discharged and the number of complaints received, both formally and through patient liaison services (PALS). Incidents reporting and actions were discussed. The meeting was also used to share information about any awards for the team and individuals. The meeting was used to share safety alerts including a new virus from Asia and information on the importance of accurate NEWS2 reporting to reduce the risks to patients. Recent incidents were discussed and actions feedback to the team and any risks including staffing, doctor cover and the breaching of the four-hour target when the department was busy. We saw that the meeting was very effective, well run and informative. The meeting was held in the main department and a relative who had overheard the meeting reported that it was very accurate and well led. Whilst this feedback was meant to be positive it also meant that patients and visitors could hear the discussions clearly which may have been a concern for confidentiality if patients had also been discussed.

Staff told us that there were several team meetings during the month. Alongside a monthly whole team meeting there were Band 7 and combined Band 6 and Band 7 meetings. Senior staff told us that the junior staff and health care assistants met every other month but that was being reviewed

as staff had said they wished to meet more often. We saw minutes for the senior meetings where staff discussed staffing cover for the unit when it was busy and action plans relating to issues raised during the month.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We noted that there were empty trolleys in the corridor that exceeded the allocated spaces available for them. Senior staff told us that these trolleys were being held in the event that there was a sudden influx of patients. They told us that it allowed the department to respond immediately without having to find trolleys from elsewhere in the trust especially if it was an emergency. We noted that these trolleys were clean and labelled for use. We asked if the rapid assessment and treatment area was sufficient in size as there were only four bays of the eight initially requested. Staff told us they hoped to extend this area to include office space but this was part of an ongoing business case for development of the department. Managers told us that expanding the size of the department would mean an increase in staff. While recruitment was difficult they told us, it was important to look at making the pathways efficient rather than build extra space.

Senior staff told us that they were able to book additional agency staff to cover busy periods and did so as a pre-emptive measure at times. During this inspection, we saw patients in the corridor at 5pm. The following morning there were still patients in the corridor. Senior staff told us that at 3pm the previous day they had booked two agency staff to support the department and corridor patients. They had also booked an extra member of staff for the following day which appeared to be appropriate as the department was still busy when we returned.

We noted that the management team held meetings within 48 hours of incidents that caused moderate and serious harm. Meetings were planned to take place twice a week so that staff were able to call in or attend in person. The meeting was chaired by the divisional governance lead and allowed the staff to share learning and experiences and plan how to prevent them occurring again. Following the inspection, we saw evidence of the discussion and learning from serious events and deaths in the form of presentations that took place regularly within the department. We were also shown minutes from governance meetings where serious incidents were discussed and action plans made to learn from them.

Managers told us they had a department and divisional risk register. The risks were discussed in the governance meetings held every two weeks and updated with action plans reviewed. Staff told us that the current risks included vacancies, achieving the four-hour target in the emergency department and the department not meeting the one-hour target for prescribing antibiotics to patients with possible sepsis. The team told us they were reviewing the documentation for managing sepsis and had a lead clinician for sepsis to lead the work.

Senior managers told us they had actions to manage pressures on the department during the winter period. The department was able to use the plan to develop pathways that could be used in times of extreme weather like snow. The team would identify staff that lived locally and would not have to drive to work, extra transport could be used to discharge patients. Extra consultants were able to cover weekends both at Basingstoke and Winchester, porters were able to support the

general assistants in the department in moving patients and the same day emergency care unit was opened at weekends if required.

Senior staff told us that there was a safe staffing review group that included a matron, chief nurse, divisional lead nurse, medical director, finance representative and bank/agency representative. Staff told us this group was established eight months ago and looked at staffing levels. The group would review sickness rates, training needs, bank and agency use, the number of patients in the department and the number of mental health and paediatric patients. This data was used to develop action plans for the department and wider trust. Senior staff told us they attended a study day run by NHS Improvements on staffing guidance and the correct levels required which also supported data used for action plans for staffing levels and business cases.

We were told that a senior manager would attend the Hampshire safeguarding children's board as a representative for the trust and feedback information to the department. This was now known as the Hampshire Safeguarding Children Partnership and was a group of local organisations that met to make sure best practice for the care and protection of children was shared across the organisations.

Information management

The service collected data and analysed it. The online audit system was not simple to use but was secure. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The information used in reporting, performance management and delivering quality care was accurate, valid, but not always reliable, timely or relevant. Staff told us that the online system for recording audits was difficult to use and action plans not straightforward to record.

We saw audit results for hand hygiene and falls on a notice board in the department. However, where one notice board stated these were discussed at the weekly communication meeting we did not observe that this was discussed at the meeting we attended. Following the inspection, we requested the most recent hand hygiene audits for the department and saw they were completed regularly with action plans for feedback to individuals and staff groups in particular during the weekly communication meeting.

Engagement

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

Senior managers told us that they had good relationships with the local care commissioning groups and social care teams. The team told us they had resilience calls with external providers twice a week to discuss issues and concerns. Staff attended additional meetings to discuss patients whose discharges were more complex and involved multiple agencies including the social care team.

The trust had a service level agreement with a mental health trust for mental health liaison and Mental Health Act management. At the time of this inspection, staff told us that this agreement was still in review to try to establish hospital wide coverage for dedicated psychiatric liaison staff.

The psychiatric liaison staff only covered the emergency departments under the current agreement.

Administration staff told us that they had been consulted and their ideas were taken onboard when changes to processes or the environment were planned. They told us this made them feel involved and they were able to make suggestions if they wished.

Learning, continuous improvement and innovation

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

Staff told us there was a positive culture and continuous encouragement for quality improvement, learning, audit and development. There was a lead consultant for quality improvement and audit and staff were encouraged to identify and then lead projects and audits.

There were three successful bids from the emergency department for Wessex Health Education England quality improvement support fund in 2019.

At the Royal College of Emergency Medicine Annual Awards 2019, the emergency department won the Emergency Department Learning Environment of the year. This reflected the ongoing work that the department was doing to encourage staff learning and education. The department had also been nominated and shortlisted for a Health Service Journal Award 2020 for the advanced clinical practice training programme used in the trust.

One staff member told us that as part of their preceptorship programme they were completing a project of their choice. They told us that they were looking at the care of patients in the corridor and how to improve it. The project was not yet completed so they had no results to share with us.

We spoke to staff who told us about numerous quality improvement projects within the department. Staff in the paediatric unit were developing a mental health triage assessment form, a review of health promotion and the use of notice boards available in the unit. The team were updating and reviewing the contents of the resuscitation area and paediatric cannulation trolley. The team told us they were intending to audit the developments and give feedback to staff in team meetings, handovers and via a team newsletter. In the main department, we were told that staff were visiting Copenhagen to share their findings after developing an obstetrics and gynaecology pathway.

Senior staff told us there was a NEWS2 focus group being set up to review how staff used the scoring system, to develop ways of improving its use and look at training for staff, in particular agency staff. This was to be a joint group with staff from Winchester. As part of the project, staff told us they were updating a sticker used in the patient records to record NEWS2 and PEWS to allow staff to add updates and actions taken as the score changed. The trust told us the group had met once in November 2019 and was to meet again in February 2020.

We were told that the team had been nominated for a team of the year award for the second year running, having won it 2018. Two staff were nominated for 'WOW' awards that celebrated success and good practice within the trust.

Medical care (including older people's care)

Facts and data about this service

The medical care service at Hampshire Hospitals NHS Foundation Trust provides care and treatment for 10 specialties: cardiology, diabetes and endocrinology, elderly care and stroke, gastroenterology, endoscopy, respiratory, neurology and rheumatology.

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

Basingstoke and North Hampshire Hospital:

Ward/unit	Number of beds	Services provided
E1	22	Gastroenterology and acute general medicine
E2	24	General medicine
E3	28	Respiratory and acute general medicine
E4	25	Diabetes, endocrinology and acute general medicine
F1	22	Acute elderly care
F2	18	Acute elderly care
F3	14	Acute elderly care
Cardiac/CCU	27	Inpatient cardiology
Isolation ward	7	General medicine
Lyford unit	4	Specialty specific day cases and infusions
Overton ward	25	Non-acute rehabilitation
Acute assessment unit (AAU)	14 beds 9 trolleys	Acute medical and frailty unit
Total	230 beds and 9 trolleys	

The trust had 46,878 medical admissions from July 2018 to June 2019. Emergency admissions accounted for 25,173 (53.7%), 402 (0.9%) were elective, and the remaining 21,303 (45.4 %) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology – 17,153
- General medicine – 14,802
- Cardiology – 3,071

(Source: Hospital Episode Statistics)

We inspected the following ward areas:

- Acute assessment unit (AAU)- Acute medical and frailty unit
- Ward F1- Acute elderly care
- Ward F2- Acute elderly care

- Ward F3- Acute elderly care
- Ward E2- General medicine
- Ward E3- Respiratory and acute general medicine
- Coronary Care Unit (CCU)- Inpatient cardiology
- Overton Ward- Non-acute rehabilitation
- Lyford Unit- Specialty specific day cases and infusions

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- Spoke with 11 patients who were using the service and three relatives of patients using the service.
- Spoke with 41 staff including; clinical matrons, ward sisters, doctors, nurses, clinical nurse specialists, ward admin coordinators and patient flow coordinators.
- Observed multidisciplinary meetings, staffing meetings, safety huddles, staff interactions and care on the wards.
- Reviewed 13 patient records.

We inspected the service as part of our routine inspection programme. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all nursing and medical staff were up to date with mandatory training.

Mandatory training completion rates: Basingstoke and North Hampshire Hospital

A breakdown of compliance for mandatory training courses from April to September 2019 for qualified nursing staff in medicine at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Counter fraud	228	239	95.4%	90%	Yes

Dementia awareness (including privacy and dignity standards)	227	239	95.0%	90%	Yes
Equality and diversity	226	239	94.6%	90%	Yes
Health and safety (slips, trips and falls)	220	239	92.1%	90%	Yes
Moving and handling	215	239	90.0%	90%	Yes
Basic life support	210	237	88.6%	90%	No
Immediate life support	210	237	88.6%	90%	No
Conflict resolution	209	239	87.4%	90%	No
Information governance	206	239	86.2%	95%	No
Fire 1 year	204	239	85.4%	90%	No
Infection control	181	239	75.7%	90%	No
Medicine management training	130	239	54.4%	90%	No

In medicine the 90% target was met for five of the 12 mandatory training modules for which qualified nursing staff at Basingstoke and North Hospital were eligible. Nursing staff did not meet the 95% trust target set for the module information governance.

Medical staff received mandatory training however it was not always kept up-to-date.

Medical staff accessed training through e-learning, but also through 'rapid courses' and teaching sessions, taught by a multi-disciplinary team.

A breakdown of compliance for mandatory training courses from April to September 2019 for medical staff in medicine at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Moving and handling	111	134	82.8%	90%	No
Conflict resolution	105	134	78.4%	90%	No
Health and safety (slips, trips and falls)	101	134	75.4%	90%	No
Basic life support	97	131	74.0%	90%	No
Immediate life support	97	131	74.0%	90%	No
Equality and diversity	98	134	73.1%	90%	No
Counter fraud	90	134	67.2%	90%	No
Infection control	90	134	67.2%	90%	No
Dementia awareness (including privacy and dignity standards)	87	134	64.9%	90%	No
Fire 1 year	81	134	60.4%	90%	No
Information governance	67	134	50.0%	95%	No
Medicine management training	7	134	5.2%	90%	No

In medicine the 90% target was not met for any mandatory training modules for which medical staff at Basingstoke and North Hampshire Hospital were eligible. In addition, medical staff did not meet the 95% trust target set for the module information governance. Medical staff we spoke with during inspection told us their mandatory training was up to date. This meant medical staff did not know what mandatory training they had to complete.

The mandatory training was comprehensive and met the needs of patients and staff. Staff felt mandatory training was enough for their role. Staff could access mandatory training modules and specialist modules on a computer platform, which staff found easily accessible.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers on the ward were aware of the mandatory training completion rates for their staff, they monitored and told staff when they had training that needed to be updated.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Safeguarding training completion rates: Basingstoke and North Hampshire Hospital

The trust set a target of 90% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff had a clear understanding of safeguarding procedures and when they would report. During inspection the staff said they had excellent support from the safeguarding team and the team were easy to contact for advice. Staff could name their safeguarding lead and how to contact them. The safeguarding team also supported staff with making referrals.

A breakdown of compliance for safeguarding training courses from April to September 2019 for qualified nursing staff in medicine at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	231	239	96.7%	90%	Yes
Safeguarding children (level 1)	216	239	90.4%	90%	Yes

The 90% target was met for both safeguarding training modules for which qualified nursing staff in medicine at Basingstoke and North Hampshire Hospital were eligible.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff told us that they accessed their safeguarding training through an e-learning system. Medical staff had a good understanding of safeguarding, when to report and how to report. However, the 90% target was not met for either of the safeguarding training modules for which medical staff in medicine at Basingstoke and North Hampshire Hospital were eligible.

A breakdown of compliance for safeguarding training courses from April to September 2019 for medical staff in medicine at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	87	134	64.9%	90%	No
Safeguarding children (level 1)	76	134	56.7%	90%	No

All staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other teams to protect them. Staff could give clear examples of different types of

abuse which would constitute a safeguarding concern. During our visit we observed safeguarding procedures for vulnerable patients. For example, we observed one-to-one care from staff in the dementia team, for a patient who was a risk of harming themselves.

All staff knew how to make a safeguarding referral and who to inform if they had concerns. Medical staff could name their safeguarding lead and how to contact them.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, cleaning records were not always up-to-date and hand sanitiser gel was not always available at the entrance to wards.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and clutter free.

The service generally performed well for cleanliness. During our visit we saw cleaning records were up-to-date, but there were some gaps in recording. For example, in wards F1, E2, E3, Coronary care unit and Lynford day unit we saw that some bays in the ward had missing records to show that they were cleaned at 7am, 2pm and 5pm. However, each bay within a ward had records to show that staff cleaned it most of the time. Data provided to us by the trust showed a domestic cleaning score including and above 97% for the medical care wards on the month we inspected.

We saw curtains around each patient's bed; each curtain had the date which it was last changed clearly displayed. Dates on the curtains showed they had been changed in the previous six months in line with guidance.

There were isolation rooms on several of the wards we looked at during our visit. These rooms were identified with clear signage, which informed staff and visitors of any special precautions needed when in contact with the patient. During our visit staff commented that there were not enough isolation rooms. However, staff were proactive at managing beds and ensuring patients that required a side room for isolation got one.

During our inspection we visited E1 ward where there had been an outbreak of norovirus and C. difficile. We were concerned that to get to ward E2, you had to pass through E1 or the isolation unit; each option presented an infection risk to patients in E2. We asked the trust for an action plan regarding this infection control concern. The trust provided us with an action plan relating to action taken on E1 ward, but it did not identify the risk relating to the potential of infection spread to E2 ward.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed proper disposal of PPE in bins which were segregated appropriately.

In clinical areas we observed staff maintain 'Bare Below the Elbows', a national initiative aimed at improving hand hygiene. Staff were observed adhering to hand washing before and after patient contact in line with National Institute for Health and Care Excellence (NICE) guidance. From data the trust sent us following the inspection, the service was consistently achieving 100% for their hand hygiene audits. However, some wards had lower compliance with hand hygiene audits for example ward F1 showed 90% compliance with hand hygiene audits in October and 70% compliance in December.

Hand sanitiser gel was found on the entrance to each ward, but the pumps did not always work. This was a risk because it meant people visiting the ward could not sanitise their hands before entering the wards, which could increase the risk of infection. We observed hand sanitiser gel at the end of each patient's bed, which were full and in working order.

Equipment was cleaned after patient contact and labelled to show it was ready for use. Staff labelled equipment with dated 'I am clean' stickers to show it was clean and ready for use. We saw staff cleaning equipment consistently.

During our inspection we looked at the sluice on each ward; they were visibly clean, organised and well maintained. The sluice was locked, and chlorine-based cleaning chemicals were stored in accordance to Control of Substances Hazardous to Health (COSHH) regulations.

Environment and equipment

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

The design of the environment followed national guidance. All floors were smooth, seamless and easily cleaned. We observed the wards had lever operated taps. Lever operated taps aid hand hygiene because once hands are washed the tap can be turned off with the elbow and not hands. We saw fire exits clearly labelled and fire doors closed. The environment on the wards was suitable for patients with dementia, we observed colour distinction on walls and hand rails. We also observed advertisement posters on the walls from a time relevant to patients with dementia and games for patients to interact with.

Staff carried out daily safety checks of specialist equipment. We saw access to emergency equipment on each ward. This included portable oxygen, suction, defibrillators and emergency drugs on purpose-built trollies. We saw records that showed the equipment was checked according to the trust protocol in most wards, but on two wards there were two days where the resuscitation trolley had not been checked. On the coronary care unit there were two days in December that the resuscitation trolley was not checked. On Overton unit there was one day missing in January and one day missing in December where the resuscitation trolley was not checked. All patient bays and rooms we visited had piped oxygen and suction and we saw records that showed staff checked these daily.

The service had enough suitable equipment to help them to safely care for patients. Beds, furniture and equipment were labelled with asset numbers and labels showing the service date. During our inspection all the equipment that we checked were all within the date of last service. We saw equipment inventory logs which contained the lifespan of a piece of equipment, last date of service and where the equipment was in use.

Staff disposed of clinical waste safely. We observed waste being disposed of in bins separated by type of waste and housekeepers disposing of waste bags appropriately. Clinical sharp waste was disposed of in appropriate sharps bins which were signed, dated and locked away.

Facilities in the service were appropriate for the needs of the patient, they were clean and clutter free. However, staff in Overton unit told us could benefit from more storage space and we saw equipment in the corridors. On some wards there was space for relatives and patients to use, this was for social use.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. In records we looked at staff had completed a National Early Warning Score (NEWS), which is a nationally recognised tool used to improve detection and response to patient deterioration. Of the records we reviewed all had a NEWS form completed and appropriate escalation process followed if necessary.

Results of NEWS audits were given a RAG rating, red colour indicated that 0-79% of NEWS assessments were completed, amber 80-89% and green 90-100% respectively. Most of the medical care wards consistently showed a green rating for NEWS completion. However, in comparison F2 ward was consistently reporting as amber and red. The trust did not provide us with an explanation for this.

Staff completed most risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. During inspection we looked at patients care plans, we saw that nurses had completed risk assessments on admission for individual patients. Risk assessments included: nursing assessment, pressure ulcer assessment, nutritional risk assessment, falls risk assessment. Risk assessments were reviewed regularly to keep patients safe.

Venous thromboembolism (VTE) risk assessments were completed in some patients' care records but this was not consistent. We found that four out of the thirteen patient records we viewed did not have a VTE risk assessment VTE and blood clots can commonly develop following hospitalisation and can cause death, risk assessments for VTE are key to help prevent it and ensure patient safety.

Staff knew about and dealt with specific risk issues. Staff had awareness of sepsis and there was a procedure for escalation that all staff are aware of. Specialised nurses delivered sepsis training. Audits for sepsis screening found that 100% of the time staff were screening patients for sepsis when they met the criteria of the local protocol for sepsis screening.

Staff could identify which patients were at risk of falls and these patients had yellow non-slip socks on rather than red: we observed this during our inspection. For incidents such as falls we were told that staff conducted and reviewed patients' care plans to prevent further incidents. We saw a call bell on a long lanyard around one patient's neck who was a risk of falls, this demonstrates that the service assesses and responds to the risk for each patient.

During our inspection we found staff knew about and dealt with risk issues. For example, in the case of one patient suffering with pressure sores we saw comprehensive notes in the patient's care plan about the pressure sores and how staff were going to deal with them. We saw the location of the pressure sores mapped to areas of the body, therefore any nurse looking after the patient would know where the pressure sores were located without examination. We saw plans for patient turning frequency, staff turn the patient to avoid worsening of pressure sores. Frequency of recommended turns in the care plan met the number of turns the patient received each day. The care plan had detailed notes from the tissue viability team and an incident number recorded.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. We saw prompt response from the mental health

liaison team and discussions were documented in the patient's notes. Staff said that support and advice from the mental health liaison team was useful and prompt.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Patient records contained mental health assessments for patients at risk and plans to minimise the risk were put into action. For example, we observed one on one care for a patient who staff had assessed to be at risk of self-harm.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Staff attended shift handovers to discuss patients on the ward and what their care needs were. Doctors and nurses attended morning 'board meetings' to ensure that all important information was shared to keep patients safe. Discharge planning was also discussed at board meetings this ensured that care was handed over successfully and that all information was shared about individual patients.

We observed documented meaningful multidisciplinary discussions around patient risk. Clinical matrons from each of the medical care wards attended a safety huddle each morning. The purpose of the safety huddle was to share information to keep patients safe.

Staff used coded pictures above the patient's bed to discreetly indicate risks associated with that patients' condition, for example we saw a sunflower representing dementia, a red food plate which showed the patient needed help with eating and a yellow foot which showed the patient was at risk of falls.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe most of the time. However, some wards had staff shortages which we saw during our inspection. Staff we spoke to during the inspection said that staffing was a concern. Safe staffing levels was mentioned on the medical division risk register and actions included; rapid replacement of vacancies, use of bank staff and recruitment strategy events including overseas. Staff told us that there was not enough support from occupational therapists and physiotherapists on the ward and staff had been told this was because occupational therapists and physiotherapists were also short staffed.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. During our inspection we observed staffing meetings which occurred daily between the clinical matrons who managed the medical care wards. During this meeting nurse and support staff numbers on each ward were calculated and these were carefully reviewed alongside guidance and the needs of patients on each ward.

The ward manager adjusted staffing levels daily according to the needs of patients. Managers reviewed and adjusted staffing levels daily, for example support staff were regularly moved around the wards to cover gaps in staffing. The medical division offered 'golden shifts'. Golden shifts consisted of two additional nursing staff who could do a shift on any ward. During the staffing meeting each morning the clinical matrons who ran each ward discussed their demand and

whether they would benefit from the golden shift for extra support. We were told by staff that wards had to use bank and agency staff to cover shifts, especially shifts during the night.

The number of nurses and healthcare assistants matched the planned numbers on most wards we visited. However, during inspection we saw that the number of actual staff did not always match the planned. For example, on F1 ward the late shift had three planned nurses but only two actual and four healthcare assistants and only two actual. We looked at the safe staffing data for each month. The data showed that F1 ward does not consistently meet planned staffing levels, this is especially apparent during the night shift.

The table below shows a summary of the nursing staffing metrics in medicine at Basingstoke and North Hampshire Hospital compared to the trust's targets, where applicable:

	Medicine annual staffing metrics						
	October 2018 to September 2019						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	618	19%	19%	4.2%			
Qualified nurses	239	28%	10%	3.7%	43,457 (9%)	44,262 (9%)	22,557 (5%)

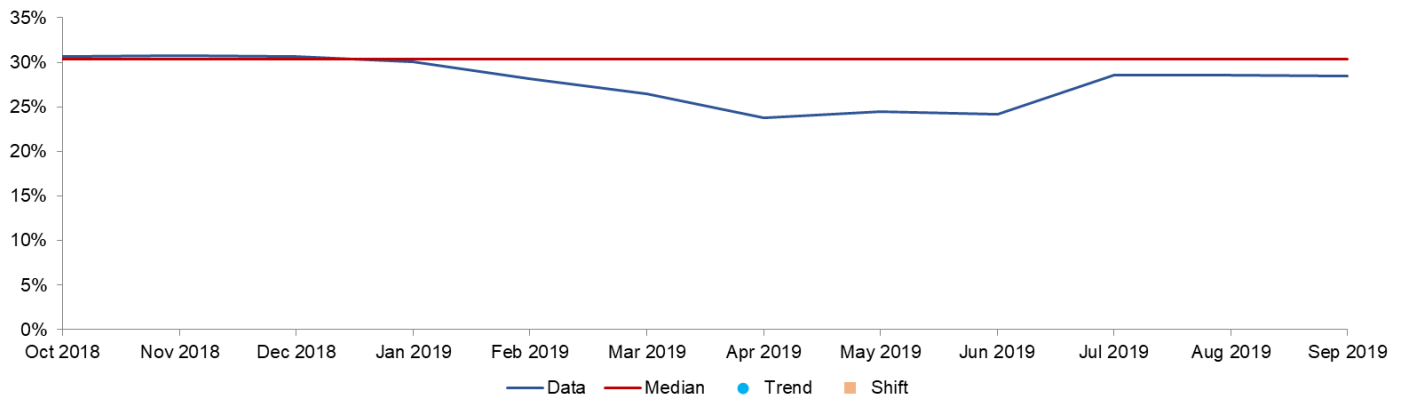
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

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

Vacancy rates

The service had vacancy rates for nursing staff that were not stable. Managers we spoke with during inspection told us that their recruitment and retention had improved. We were told by managers that vacancies are in active recruitment currently. In some wards the clinical matrons told us that they have new nurses starting in the next couple of weeks. We saw performance documents from the medicine division which said evidence that the chief nurse was actioning vacancy shortfalls in the medicine division by completing a vacancy trajectory exercise and an apprenticeship review with the matrons.

Vacancy rate - registered nurses



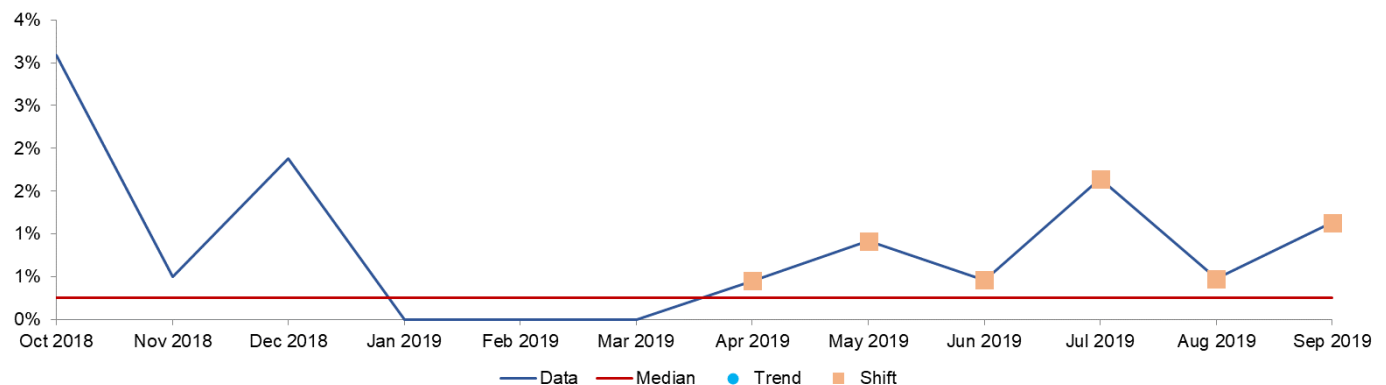
Monthly vacancy rates over the last 12 months for registered nurses were not stable and may be subject to ongoing change.

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

Turnover rates

The service had low but increasing turnover rates for nursing staff. We discussed turnover rates with managers during inspection. We were told that they offered wellbeing support to staff and adhere to an 'open door policy' so staff feel welcome to talk to managers with any concerns. With support for staff and a good working environment culture, managers hoped this would influence reducing staff turnover moving forward.

Turnover rate - registered nurses



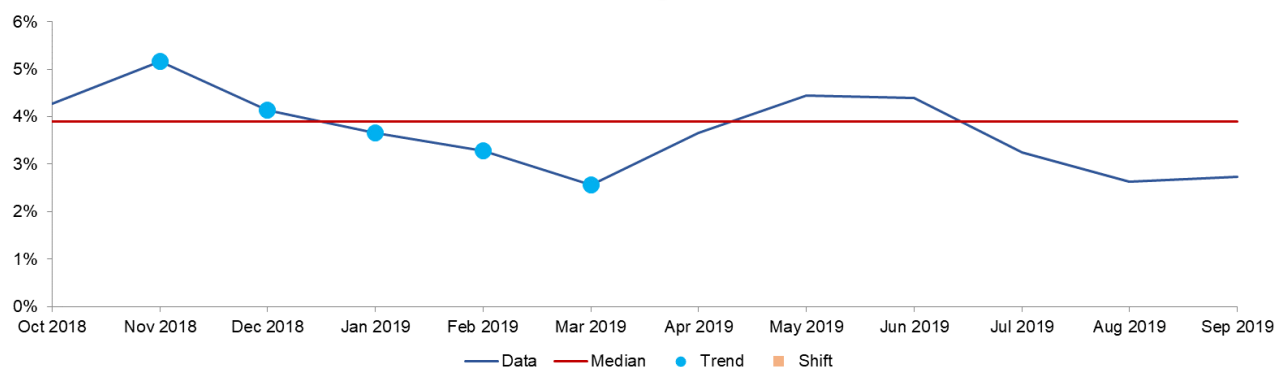
Monthly turnover rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019. This could be an indicator of change.

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

Sickness rates

The service had reducing sickness rates for nursing staff.

Sickness rate - registered nurses



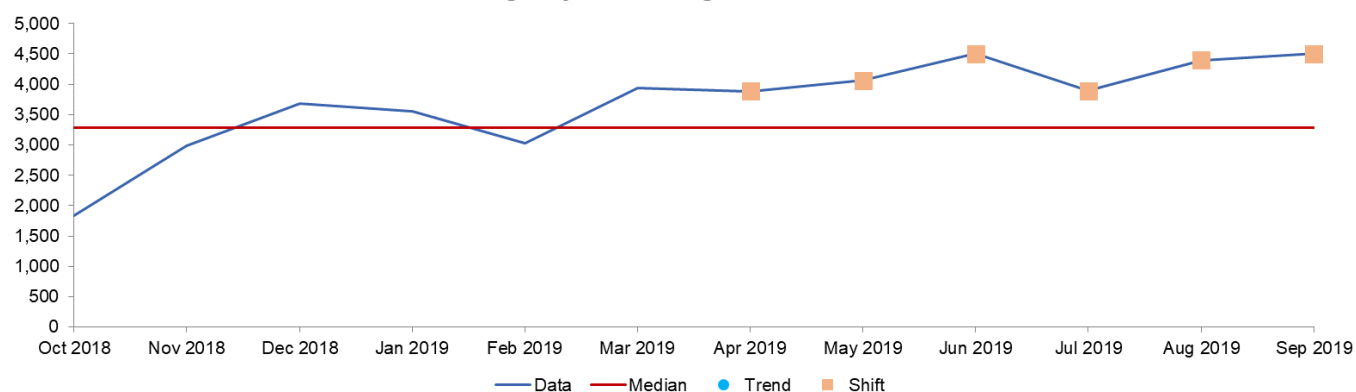
Monthly sickness rates over the last 12 months for registered nurses show a downward trend from November 2018 to March 2019. This could be an indicator of improvement.

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

Agency staff usage

The service had increasing rates of bank and agency nurses. We were given conflicting information. Ward managers told us they used agency staff but very rarely. However, ward managers also told us that there is a high use of agency nurses to fill the night shifts and that continuity of staff at night was difficult. This was different to what our data showed as monthly agency use over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019. This could be an indicator of change.

Agency hours - registered nurses



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

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff we spoke to told us they aimed to limit the use of agency staff, preferring to fill spaces with overtime and regular bank staff who are familiar with the service and the patients. Ward managers said that regular bank staff were preferred to improve continuity of care.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers we spoke with told us that bank and agency staff on their ward had a full comprehensive induction. Staff said that they try to use the same agency staff, so they have a full understanding of the service.

Medical staffing

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

The service had enough medical staff to keep patients safe. During our inspection the wards we visited had enough medical staff to keep patients safe. We reviewed records on inspection and all the records showed that a consultant had seen each patient at least once a day. From the notes we saw that a consultant twice daily reviewed patients whilst in the acute assessment unit and once daily when on the hospital wards.

The medical staff matched the planned number. The number of medical staff on the wards matched the planned numbers. The medical division had a team dedicated to medical outliers, medical outliers are medical patients who are placed on other non-medical wards due to lack of available beds. Medical staff told us that the introduction of the dedicated medical outliers' team was beneficial to them because it reduced the time spent off the wards searching for their medical outliers.

Trust level

The table below shows a summary of the medical staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

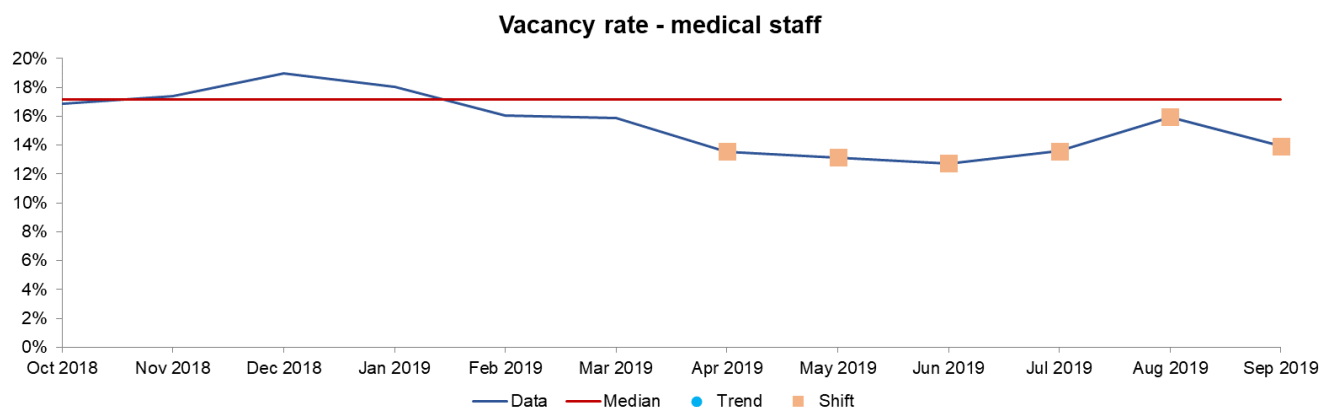
	Medicine annual staffing metrics						
	October 2018 to September 2019						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual locum hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	1,622	17%	17%	3.7%			
Medical staff	206	16%	28%	1.2%	25,054 (6%)	8,559 (2%)	

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

Medical staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and locum use.

Vacancy rates

The service had reducing vacancy rates for medical staff.

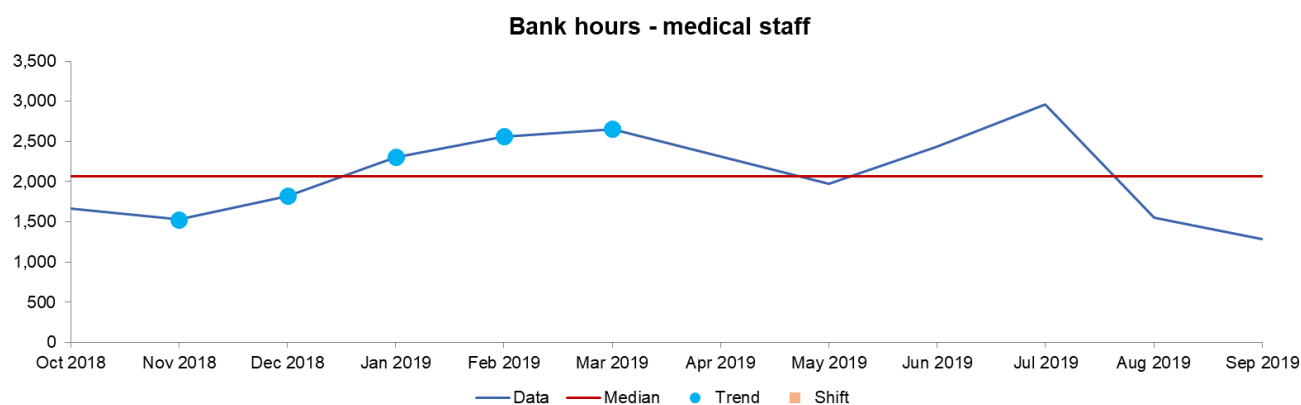


Monthly vacancy rates over the last 12 months for medical staff show a downward shift from April 2019 to September 2019. This could be an indicator of change.

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

Bank staff usage

The service had increasing rates of bank and locum staff.



Monthly bank use over the last 12 months for medical staff show an upward trend from November 2018 to March 2019.

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

Basingstoke and North Hampshire Hospital

The table below shows a summary of the medical staffing metrics in medicine at Basingstoke and North Hampshire Hospital compared to the trust's targets, where applicable. Please note that Hampshire Hospitals NHS Foundation Trust has some medical staff that work across sites and therefore are not allocated to a specific site. These staff are captured under the trust level figures.

	Medicine annual staffing metrics						
	October 2018 to September 2019						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual locum hours (% of available hours)	Annual unfilled hours (% of available hours)

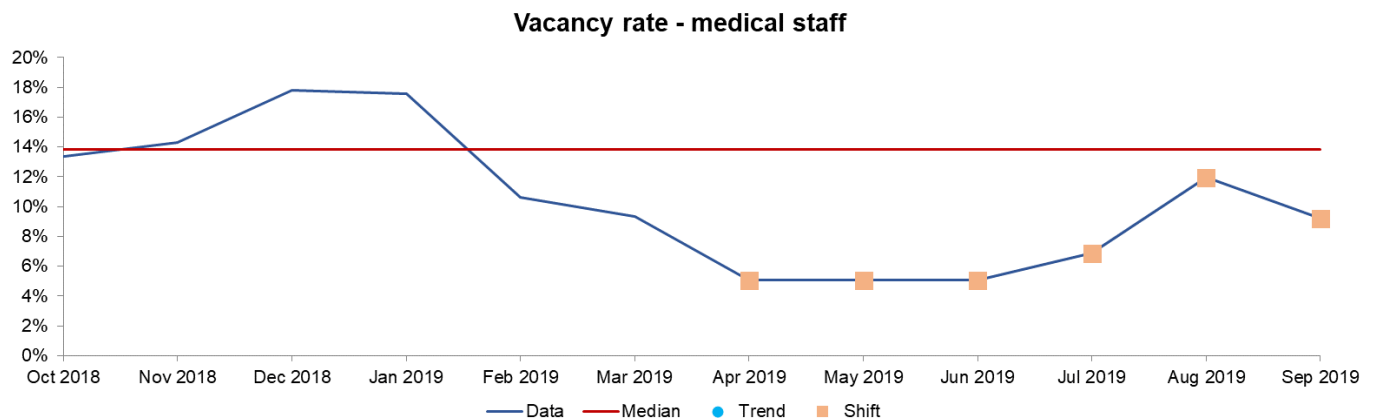
Target		8%	12%	3.5%			
All staff	618	19%	19%	4.2%			
Medical staff	109	10%	32%	1.7%	24,877 (12%)	5,852 (3%)	0 (0%)

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

Medical staffing rates within medicine at Basingstoke and North Hampshire Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and locum use.

Vacancy rates

The service had reducing vacancy rates for medical staff.

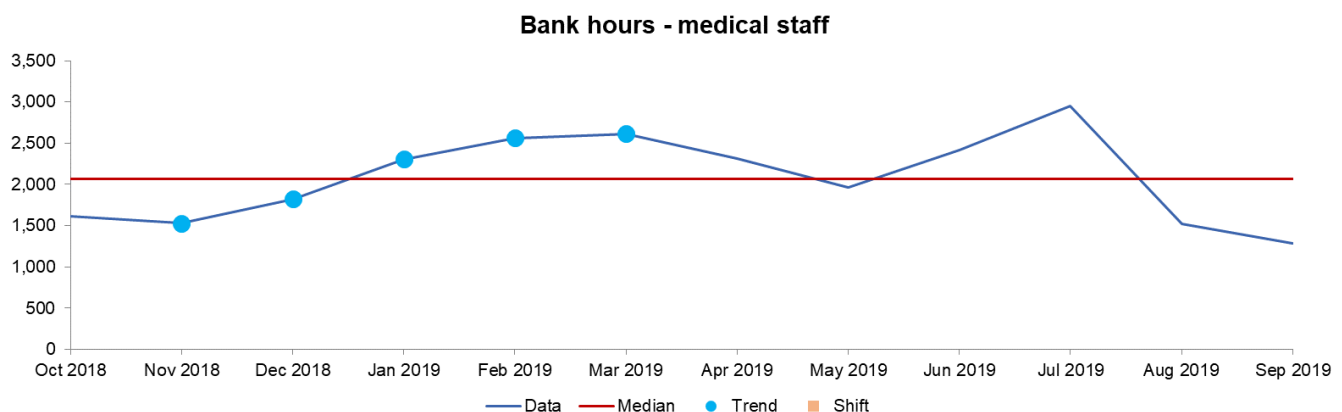


Monthly vacancy rates over the last 12 months for medical staff show a downward shift from April 2019 to September 2019. This could be an indicator of change.

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

Bank staff usage

The service had increasing rates of bank and locum staff. There were enough numbers of medical staff on the wards to safely meet the needs of patients. All medical staff met with during the inspection were permanent members of staff and not bank or locum staff, therefore we did not see an increased use of bank and locum staff.



Monthly bank use over the last 12 months for medical staff show an upward trend from November 2018 to March 2019. This could be an indicator of change.

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

Records

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

Patient notes were comprehensive, and all staff could access them easily. During our inspection we looked at 13 sets of patient notes. On each set of notes we saw that the grade of the doctor or nurse reviewing the patient was clearly documented, notes were legible and easy to understand, and all notes were signed and dated. We saw consultant input within 12 hours of patient admission and then daily review by senior clinicians, care plans, risk assessments and management plans for risks identified. Notes also showed multidisciplinary input, for example mental health liaison, dementia liaison and discussion with the pain team.

Notes also documented discussions with relatives and carers, especially regarding patients who lacked capacity.

Staff providing care for each patient could easily access the notes.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients nursing, and medical notes moved with them when they moved wards and staff could instantly see patient records on computers so there was no delay in staff accessing records.

Records were stored securely. On all the wards we visited notes were locked in digital-locking wheeled trolleys and ensured that patient confidential information was kept private. Nursing notes were found at the end of patients' beds for easy access. Additional medical patient notes were accessed on computer terminals throughout the wards. These computers were generally locked.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines most of the time.

Most of the time, staff followed systems and processes when safely prescribing, administering, recording and storing medicines. However, we found two missing FP10 forms on the acute assessment unit. FP10 forms are used to prescribe medicines, therefore they must be kept secure and accounted for. Staff were not aware of two being missing. During our inspection we also saw one dose of a patient's morphine on the acute assessment unit not documented at all.

Most of the medicines that were checked during inspection were in date and recorded correctly in medicines log book. However, we found one insulin syringe that was out of date on the acute assessment unit.

Records showed that fridge temperatures were generally maintained in a safe range. On the acute assessment unit on one day we found that the fridge temperature had exceeded the desired range (between four and eight degrees centigrade) and there was no action recorded by staff. However, on E3 ward we saw effective escalation procedures documented when a fridge temperature was high.

During our inspection a medical staff member expressed concerns that there was a potential for missed medicines while patients were transferred from the emergency department to the wards. Concerns were centred around the fact that the emergency department use a paper-based system to record medicines whereas the wards used an electronic system. We did not see instances missed medication during our inspection however.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. In patient notes we saw that staff reviewed patients' medicines regularly. For example, we saw antibiotic review of a patient.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Every ward stored medicines in locked trolleys on the wards and in locked rooms with locked store cupboards for controlled drugs. Records showed that staff had completed daily checks of medicines stock and resuscitation trolleys. On every ward there were oxygen cylinders, which were full, in date and stored correctly. The wards had a ward pharmacist who ordered stock. Pharmacists visited the wards regularly to remove patients' medicines that were no longer needed. The service showed compliance with the hospitals medicine security policy and audits confirmed this.

Staff followed current national practice to check patients had the correct medicines. We saw patients' allergies recorded in patient notes. During our inspection we observed staff confirming patients name, date of birth and allergies before administering medicines. Medical staff used electronic prescribing systems, which only one member of staff could access at a time, this was to ensure medicines were not being recorded by multiple staff at the same time; which can lead to medicines errors.

The medical division held medical event review groups twice a month to discuss any serious incidents, root-cause-analysis and incidents relating to medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke to could describe what incidents would need to be reported, who they would report them to, and how they reported them.

Staff raised concerns and reported incidents and near misses in line with trust policy. During our inspection we saw staff report incidents and follow the trust policy. For example, we witnessed a patient who spilt hot tea down themselves. On return to the ward the next day we saw that the staff had acted immediately to make the patient safe, completed an incident form on the trusts' online system and continued monitoring the patient to ensure they were safe.

Staff knew how to report incidents and they were investigated, lessons learnt were shared with staff. For example, on the cardiac ward visited during our inspection we observed information about an incident on a notice board in the ward. This incident discussed a patient who experienced a fall, following medication given that would reduce the patient's blood pressure. This patient had showed low blood pressure for two days prior. The outcome of this incident and the

learning shared with staff was to check patient's blood pressure before giving them antihypertensive drugs.

Never Events

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

From December 2018 to November 2019, the Basingstoke and North Hampshire Hospital reported one never events for medicine: A medication incident meeting SI criteria took place in October 2019 at Basingstoke and North Hampshire Hospital. The incident involved a patient who was administered a second dose of prescribed weekly methotrexate within 24 hours. We saw a full root-cause-analysis for this never event, this included investigation, duty of candour requirements and shared learning.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS: Basingstoke and North Hampshire Hospital

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, Basingstoke and North Hampshire Hospital reported 25 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2018 to November 2019. A breakdown of incidents by incident type is below:

Incident type	Number of incidents	Percentage of total
Pressure ulcer meeting SI criteria	9	36.0%
Slips/trips/falls meeting SI criteria	8	32.0%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	3	12.0%
Treatment delay meeting SI criteria	3	12.0%
Medication incident meeting SI criteria	1	4.0%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	4.0%
Total	25	100.0%

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We saw a record of staff having a discussion with the patient, who had been given an overdose of methotrexate, to explain what had happened and how the hospital was investigating the never event. Staff understood the principles of duty of candour and when it would be applied. We observed duty of candour reporting structure in staff rooms; this meant that staff knew who to report to. We were told by staff that they received duty of candour training regularly.

Managers investigated incidents thoroughly. Managers investigate incidents thoroughly and we saw examples of this on inspection. We saw staff had conducted a root cause analysis

investigation because of never events and incidents. Root cause analysis undertaken by the hospital were thorough. They explained what the situation was, how the incident occurred and what lessons were learnt.

Staff received feedback from investigation of incidents. There was evidence that changes had been made because of feedback. Managers shared learning about never events with their staff. Staff told us that lessons learnt from never events was fed-back to them through discussions with their manager at team meetings. However, we did not see evidence of this in team meeting minutes to corroborate this. We looked at root-cause-analysis following incidents and detailed in these reports were methods of staff communication of learning. Learning communication included the root-cause-analysis report being shared with involved ward teams. We saw learning from incidents displayed in wards we visited during inspection, so staff and patients could easily see it. Patients and carers were involved in the investigations and were given a copy of the investigation report.

Staff met to discuss the feedback and look at improvements to patient care. During daily ward meetings staff discussed incidents, what they had learnt from that incident and consequently how they improved the care for that patient moving forward.

The divisional senior team monitored and reviewed incident reporting through monthly governance summary dashboard data. This data shows the number of incident reports that are open and the level of patient harm these incidents meet. The data is ward specific, so the senior team have oversight of each ward's performance.

Safety thermometer

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

Patient safety data was displayed on wards for staff and patients to see. The safety thermometer is used to monitor patient harm. Patient safety data was monitored, and we observed safety data audits results displayed on the wards. For example, audits reported included: record keeping, falls, call bell response times, nutrition, hand hygiene, pressure ulcers, dementia and NEWS2. Data displayed gave a percentage in line with the trust expectation, so staff, patients and visitors could see how the ward was performing in comparison with policy.

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

Data from the Patient Safety Thermometer showed that the trust reported 48 new pressure ulcers, 20 falls with harm and 26 new urinary tract infections in patients with a catheter from October 2018 to October 2019 for medical services. There are no noticeable trends in the safety thermometer data below.

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

Total Pressure ulcers (48)



Total Falls (20)



Total CUTIs (26)



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver according to best practice and national guidance. Staff could access policies on the trust wide intranet. Policies were up to date and reflected national guidance.

During an interview with the clinical leads for the medical division we were told that they measured performance against national guidelines. Minutes from the Clinical Effectiveness Group showed discussion of assurance that staff were implementing national and local guidelines to ensure best practice in the trust.

The hospital documented compliance with National Institute for Health and Care Excellence (NICE) guidelines. In information the trust sent us the medical division was compliant with all the NICE guidelines it measures itself against. Examples of these included: Autism in adults, Hypophosphatemia in chronic kidney disease, Falls and Head injury.

Staff protected the rights of patient's subject to the Mental Health Act and followed the Code of Practice. Patients subject to the Mental Health Act were monitored by the psychiatric liaison team

and the team made sure these patients' rights were protected. Staff on the wards could refer to the psychiatric liaison team for advice and support.

In the wards we visited we also observed 'focus on' boards, which intended to highlight themes to staff and relatives of patients. During our visit we saw 'focus on' boards with information about mouthcare and Parkinson's disease. The 'focus on' boards were there to highlight and promote trust guidance and best practice to staff, relatives and patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service planned for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients told us that staff helped them order food and drink from hospital menus. We observed a choice of food and drink was available and it was offered to patients regularly.

Staff understood patients' nutritional needs. Patients drink preferences were displayed, for example we saw "drinks only her own black tea". Making it easy for staff to identify patients needs and preferences. We saw staff asking patients if they had religious or cultural needs in terms of their food and drink on admission to the wards. Patients had access to food which met their religious or cultural needs. We saw magnetic cards above patients' beds with signs to indicate specific food needs for each patient where necessary.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Fluid and nutrition charts were completed in all the 13 patients records we looked at during our visit.

Staff used a national recognised screening tool to monitor patients at risk of malnutrition. In patient records we saw staff had completed a nutrition risk tool. This tool is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. Staff could refer a patient on their ward to the dietetics and speech and language therapy teams for additional advice and support.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff reviewed patient's pain during ward rounds. Staff used a specialist assessment tool (the Abbey Pain Scale) for patients who had cognitive impairments and could not verbalise their pain. The Abbey pain scale is a tool used to assist with assessment of pain for patients who cannot communicate their needs.

Staff referred patients to the pain team if they wanted specialist advice. We saw notes from the pain team in the patients' records.

Patients received pain relief soon after requesting it. Patient notes demonstrated timely access to pain specialists for pain medicines advice. Patients we spoke with said they received pain relief in a timely manner. A patient we spoke with said "I think they care here. I am in pain. The doctor and nurses always ask me if I'm in pain."

Staff prescribed, administered and recorded pain relief accurately. Pain relief was documented in the care plans and we saw nurses review pain and pain relief regularly as part of patient observations.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The medical division participated in relevant audits which included: Cardiac arrhythmia, Heart failure, Myocardial Ischaemia, Inflammatory bowel disease, Lung cancer, Inpatient falls, Chronic Obstructive Pulmonary Disease, Sentinel Stroke National Audit Programme (SSNAP) and Dementia. Outcomes for patients were not always positive, consistent and met expectations, such as national standards.

The endoscopy service was accredited by the Joint Advisory Group (JAG).

Managers and staff used results from clinical audits to improve patients' outcomes. Managers reviewed information from audits and used information in discussions with staff to drive improvements. Improvement was checked and monitored by regular discussion in ward meetings. For example, patient falls were reported and monitored at the daily safety huddle.

Relative risk of readmission: Basingstoke and North Hampshire Hospital

From June 2018 to May 2019, patients at Basingstoke and North Hampshire Hospital had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England average.

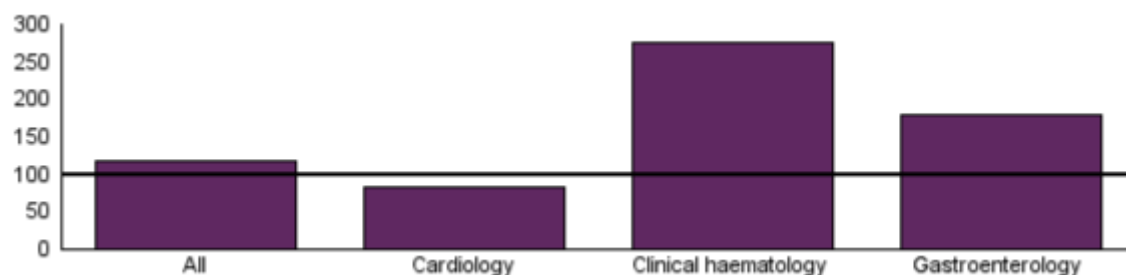
Elective admissions

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

Non-elective admissions

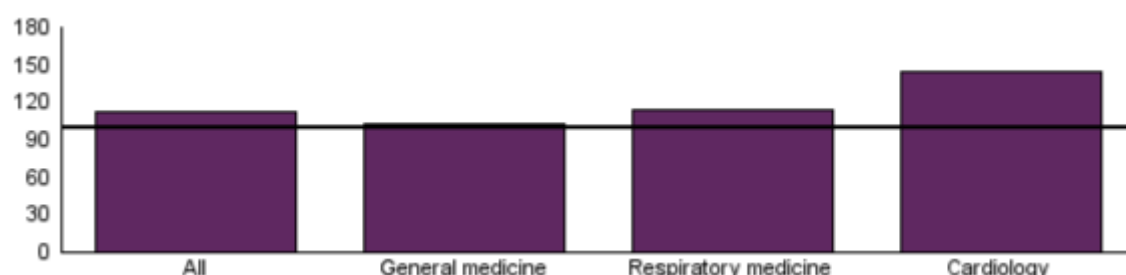
- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions

Elective Admissions - Basingstoke and North Hampshire Hospital



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

Non-Elective Admissions - Basingstoke and North Hampshire Hospital



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

During our inspection we spoke with the clinical leads for the medical division. We were told that at Basingstoke and North Hampshire hospital they were trialling ambulatory services for gastroenterology and respiratory patients. The though process behind trialling this service was to improve re-admission rates for these patients.

Lung Cancer Audit

The table below summarises Hampshire Hospitals NHS Foundation Trust's performance in the 2018 National Lung Cancer Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Met national standard?
Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)	68.1%	Does not meet the audit aspirational standard	Did not meet
Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)	34.3%	Within expected range	No current standard
Case-mix adjusted percentage of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the	18.0%	Within expected range	Met

<i>differences in the case-mix of patients seen)</i>			
Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment <i>(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</i>	63.5%	Within expected range	Did not meet
Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy <i>(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</i>	64.1%	Within expected range	Did not meet

(Source: National Lung Cancer Audit)

During our inspection we spoke with the lung cancer lead clinicians. They had recruited more staff to support the service and the clinicians thought that this was having a positive impact on patient outcomes. We discussed the results of the National Lung Cancer Audit and clinicians felt they had used the results to improve care and treatment and they are seeing an improvement in results. For example, the lung cancer lead clinicians told us the clinical nurse specialist (CNS) role has been developed and all patients currently see the CNS. We were told the CNS is involved in all stages of the patient journey to provide consistency in care and support to the patients.

National Audit of Inpatient Falls

The table below summarises Basingstoke and North Hampshire Hospital's performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

Metrics (Audit measures)	Hospital performance	Audit's Rating	Met national aspirational standard?
Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?	Yes	N/A	Met
Crude proportion of patients who had a vision assessment (if applicable) <i>(Having a vision assessment is indicative of good practice in falls prevention)</i>	86.7%	Green	Did not meet
Crude proportion of patients who had a lying and standing blood pressure	0.0%	Red	Did not meet

assessment (if applicable) <i>(Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</i>			
Crude proportion of patients assessed for the presence or absence of delirium (if applicable) <i>(Having an assessment for delirium is indicative of good practice in falls prevention)</i>	7.1%	Red	Did not meet
Crude proportion of patients with a call bell in reach (if applicable) <i>(Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</i>	85.7%	Green	Did not meet

We did not receive information on an action plan regarding this audit. However, we saw of the hospital was complying with NICE guidance on falls.

Chronic Obstructive Pulmonary Disease Audit

The table below summarises Basingstoke and North Hampshire Hospital's performance in the October 2018 to April 2019 Chronic Obstructive Pulmonary Disease Audit.

Metrics <i>(Audit measures)</i>	Hospital performance	Audit's Rating	Met national standard?
Percentage of patients seen by a member of the respiratory team within 24hrs of admission? <i>(Specialist input improves processes and outcomes for COPD patients)</i>	63.6%	Better than the national aggregate	Met
Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) <i>(Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)</i>	100.0%	Better than national aggregate	Met
Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival <i>(NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</i>	0.0%	Worse than the national aggregate	Did not meet
Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy <i>(Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</i>	72.4%	Better than the national aggregate	Met
Percentage of patients for whom a	87.5%	Better than the	Met

British Thoracic Society, or equivalent, discharge bundle was completed for the admission <i>(Completion of a discharge bundle improves readmission rates and integration of care)</i>		national aggregate	
Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file <i>(A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</i>	0.0%	Worse than the national aggregate	Did not meet

The hospital has created an action plan to address shortfalls identified in this audit. The action plan states the hospital were planning to train further staff in the use of spirometry, improve the offer of smoking cessation therapy and smoking cessation advisors will be visiting respiratory wards regularly. We did not see evidence of this at the time of our inspection.

National Audit of Dementia

The table below summarises Basingstoke and North Hampshire Hospital's performance in the 2018 National Audit of Dementia.

Metrics (Audit measures)	Hospital performance	Audit's Rating	Met national standard?
Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good <i>(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</i>	75.0%	Similar	No current standard
Percentage of staff responding "always" or "most of the time" to the question "Is your ward/ service able to respond to the needs of people with dementia as they arise?" <i>(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</i>	72.2%	Similar	No current standard
Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium <i>(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</i>	62.5%	Worse	No current standard

Multi-disciplinary team involvement in discussion of discharge (Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)	91.7%	Better	No current standard

The hospital had created an action plan to address the shortfalls identified in this audit. Actions included: improving assessment for delirium using a standardised tool, reduction of bed moves for patients with dementia and delirium.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had completed relevant training to meet the needs of patients on their ward. Staff had access to specialist training through teaching sessions and by using the trust's online training system. Staff said training was easily accessible and they were given enough time to complete training. Staff told us they attended regular conference and study days.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff received dementia awareness training, mental health and learning disability training. Staff told us they could easily access advice from the dementia care team, older people mental health team and learning disability team.

Junior medical staff told us they had received enough training, were given time for additional learning and development and were supported by the senior consultants.

Managers gave all new staff a full induction tailored to their role before they started work. Induction included mandatory training modules that all staff had to complete and training modules specific to their role. Staff felt competent to carry out their roles and said that they had enough support available if needed.

Appraisal rates: Basingstoke and North Hampshire Hospital

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they had regular appraisal that was meaningful and constructive.

As at September 2019, 91.5% of staff within medicine at Basingstoke and North Hampshire Hospital received an appraisal compared to a trust target of 90%.

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add prof scientific and technic	7	7	100.0%	90%	Yes
Medical and dental	47	50	94.0%	90%	Yes

Additional clinical services	151	161	93.8%	90%	Yes
Estates and ancillary	9	10	90.0%	90%	Yes
Administrative and clerical	54	61	88.5%	90%	No
Allied health professionals	13	15	86.7%	90%	No
Nursing and midwifery registered	151	175	86.3%	90%	No
Total	432	479	90.2%	90%	Yes

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. Staff received regular supervision of their work and staff felt supervision was constructive. Managers told us one of the best parts of their job was to support nurses and enable them to grow.

The clinical educators and specialist teams supported the learning and development needs of staff. Specialist clinical teams led learning and development sessions with the nursing and medical staff. For example, staff told us they attended specialist pain training from the pain team.

Staff were supported to develop their skills and knowledge and were given time for learning and to complete training. Medical staff could attend learning sessions over breakfast every Wednesday morning, multidisciplinary teams taught these sessions. Staff also had access to 'rapid courses' such as recognition of deterioration of patients.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff felt supported by their manager to develop and we saw this at different staff levels in the service. For example, we spoke to a ward sister who was being supported to complete a master's degree. The ward sister told us the trust was paying for the degree and she was given protected time to study. A healthcare assistant we spoke with said "they are sending me to do my nurse training, I'm only an HCA. I never thought I could be a nurse."

Managers made sure staff received any specialist training for their role. For example, staff received specialist training from the pain team around pain management. Specialist teams such as psychiatric liaison and the dementia team had training specific for their role. We did not see evidence of competency assessment for specialist roles.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff held daily meetings on the ward with a multidisciplinary team to discuss each patient and how they can improve their care. We observed daily team meetings during our inspection, these meetings were multidisciplinary had enough challenge and had no obvious hierarchy. They discussed patients with a holistic approach to improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw consistent and regular multidisciplinary input in patients care records. Staff could refer for specialist advice using the trust's e-referral system. Staff said responses to e-referrals were prompt and helpful. We saw efficient multidisciplinary team work. Staff received proactive

support from the microbiology team, who come to the wards rounds and assist with taking blood samples from patients.

The service routinely referred for specialist help using an e-referral system, staff told us how referrals were responded to in a prompt manner. The service could refer for support from physiotherapists and occupational therapists, however, staff said they would like more support; but physiotherapists and occupational therapists were short staffed

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff regularly referred for mental health assessments from the psychiatric team, older people's mental health team and the dementia team. We saw input from mental health teams in patients notes any input and advice from the mental health teams was actioned promptly.

Patients had their care pathway reviewed by relevant consultants. Each team member was aware of who has responsibility for an individual patient's care.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Relevant consultants reviewed patients within 12 hours of admission to a ward and consultants led daily ward rounds, this was seen in the patient records we reviewed.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The service had doctors that were on call for support and advice. Staff could get support from other disciplines when needed. However, staff said they would like more support from occupational therapy and physiotherapy.

We looked at the trust's strategy towards seven-day working. The trust reported they have met the seven-day standard for: time to first consultant review, access to diagnostic testing and reporting, access to consultant directed interventions, and ongoing daily consultant review for inpatients. The trust measured their performance against the seven-day hospital clinical standards and we saw a document from the trust with evidence of trust compliance with the clinical standards.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and units. During our inspection we observed information in the form of posters and leaflets that promoted a healthy lifestyle and support. Information was presented in a way that patients could understand, and we were told information could be printed in larger print for patients who needed it. However, we did not see any information written in other languages, but we were told staff could access translation services if they required it.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff identified patients who needed extra support and they made plans to help them. Staff empowered patients to manage their own health, for example we saw two staff support a patient out of bed to enable the patient to walk to the toilet rather than make the patient use a bedpan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff protected the rights of patient's subject to the Mental Health Act and followed the Code of Practice. Staff had a good understanding of consent and we were told that doctors, psychiatric liaison team or dementia team would make best interest decisions. Best interest decisions are used for individuals who have been assessed to lack capacity, 'decision-makers' decide care for that patient in line with what they know about the patient. In all the patient notes we saw assessment of capacity.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff demonstrated good understanding about how to support patients experiencing mental ill health, when to assess capacity of a patient and make decisions about their care. We saw capacity assessments in patient care records.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us the mental health team, dementia team and learning disabilities team were responsive and offered helpful advice.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. We were told that doctors and the mental health liaison team would be involved in best interest decisions for a patient. Doctors and the mental health liaison team made best interest decisions considering the patient's wishes, cultures and religious traditions. Where there was a lack of capacity we saw input from family, if they had lasting power of attorney, in their care records.

Staff made sure patients consented to treatment based on all the information available. Staff made sure to give patients all available information in a way that patients could understand, to ensure that patients could consent to treatment knowing all the options available to them. For example, patients receive information in a written format and staff take time to explain treatment in a way that the patient would understand. Staff told us they wait for a relative to be with the patient if that was preferred.

Staff clearly recorded consent in the patients' records. In all the patient records we looked at we saw consent recorded. We did not consistently see evidence in the patient records of staff seeking consent for patients' names to be on the boards in the wards. However, patients told us that staff did ask for consent for their name to be on the ward.

We were told by staff that they did not use rapid tranquilisation on the wards and they would use de-escalation techniques to deal with violence and aggression. Staff attended mandatory conflict resolution training. During our inspection staff could not find us the policy on rapid tranquilisation. However, we were told that the rapid tranquilisation policy had recently been written and was being reviewed by a panel at the next panel meeting.

Mental Capacity Act and Deprivation of Liberty training completion: Basingstoke and North Hampshire Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Basingstoke and North Hampshire Hospital for qualified nursing staff in medicine is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	155	231	67.1%	90%	No

Nursing received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, but it was not always kept up to date. In medicine the target was not met for MCA/DoLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from April to September 2019 at Basingstoke and North Hampshire Hospital for medical staff in medicine is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	67	128	52.3%	90%	No

Clinical staff received training on the Mental Capacity Act and Deprivation of Liberty Safeguards, but it was not always kept up to date. In medicine the target was not met for MCA/DoLS training modules for which medical staff were eligible.

During our inspection we saw patients who had Deprivation of Liberty Safeguards as part of their care. Doctors and the mental health liaison team would review the patient's care plan and actioned plans to restrict that patient's liberty only when necessary and appropriate. For example, on E2 ward a patient had Deprivation of Liberty Safeguards as part of their care plan because they frequently absconded from the ward.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff taking time to talk and interact with patients and those close to them with kindness and respect. Patients were reassured with compassion when in pain or confused. We observed staff acting responsively when caring for patients for example, call bells were answered promptly.

Patients said staff treated them well and with kindness. During our visit we spoke to patients, feedback about the staff was overwhelmingly positive. Examples of patient comments include; "the quality of care here is excellent", "this is a great hospital, the staff go the extra mile for you here". A relative we spoke to during our visit commented, "the staff here are kind and caring, they saw my mum quickly". During our visit we observed a nurse who recognised a patient from a previous

hospital stay and put the patient in the same bed on the ward on admission. We observed healthcare assistants sitting with patients and doing their hair or helping them to knit.

Staff followed trust policy to keep patient care and treatment confidential. Staff pulled the curtains around patients when giving personal care and when doctors were examining patients. We observed staff pull curtains around individual patients whilst they were getting out of bed to protect their dignity. Patients we spoke with commented that their privacy and dignity was respected.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During our visit staff showed a non-judgemental attitude. For example, we saw a healthcare assistant talking to a patient with dementia who wanted to leave the ward in kind and compassionate way. During our inspection, a patient told a member of the inspection team "I get confused and they do not make me feel stupid."

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to their dietary needs, but staff did not consistently document personal, cultural, social and religious needs of patients and how they may relate to care needs. During our visit we observed staff asking patients questions around nutrition and hydration needs to understand the patients personal, cultural, social and religious needs. However, we did not see consideration of personal, cultural, social and religious needs of patients documented in their care plan and how they may relate to the patients care needs. This could affect care for individual patients as staff may not be considering what is important to patients when planning their care.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The wards we visited had separate bays for female and male patients. In the acute assessment unit, the manager told us they could adapt the number of female and male beds according to demand and would frequently change male and female only areas of the unit to accommodate this. The service reported no mixed sex breaches relating to medical care wards in the reportable period.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff sought specialist support from the dementia team, learning disabilities team and psychiatric liaison for patients who required additional emotional support and care. We observed one-to-one care from the dementia team with a patient who required emotional support. The hospital runs a 'dementia carers café' once a month to support relatives and carers of patients with dementia.

The trust had a chaplaincy service. Patients and relatives could always access the chapel for reflection and prayer. Patients and relatives could contact the chaplain for support.

Staff supported patients and relatives who became distressed in an open environment and helped them maintain their privacy and dignity. For example, during inspection we saw a consultant speaking to the relative of a patient who was visibly upset in a separate room away from the ward. Staff told us they encourage patients to use the 'Sunflower Suite' when they were distressed. This room is a dementia friendly room consisting of games, objects and a computer system which could play music from a period relatable to elderly patients with dementia. Staff expressed that this room

was useful in helping patients when they were distressed, and it helped them to maintain privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. For example, during our inspection one patient was identified by medical staff with mental illness, the patient's family found their relatives condition had an impact on their wellbeing. Staff made arrangements for this patient and their relative to ensure they had the appropriate emotional and medical support.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. During handover meetings we observed staff discussed psychological and emotional needs of patients and how this effected relatives and carers. We saw that patients were given timely assessment from the mental health team if they were suspected of experiencing depression.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff used 'This is Me' document to encourage staff to involve patients and those close to them in their care and treatment. Patients we spoke to during inspection commented that "they (staff) keep me informed at all times about what is happening" and "my family are kept informed". We were told by staff that they actively encouraged relatives and carers to come to visit their relative and help with meal times and personal care if they wanted to.

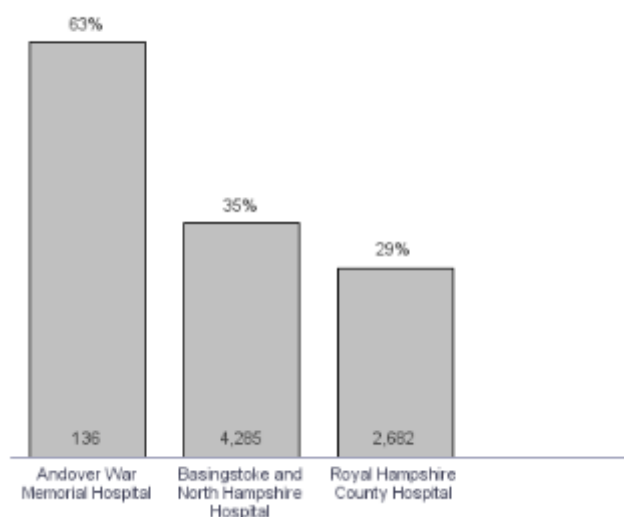
Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff told us patients and those close to them would often give verbal feedback to staff. Staff receive feedback using feedback forms which are filled in by patients and put in a designated box on the ward, staff supported and encouraged patients and relatives to do this. Patients had the opportunity to nominate staff for "WOW!" awards, we saw notice boards on each ward showing staff who had been given these awards.

Staff supported patients to make informed decisions about their care. Staff told us they actively involve patients and those close to them in the design of their care plans. Staff considered patients and relatives wider circumstances and gave them options for care and discharge decisions. Staff agreed care plans with the patient and had a meeting with the family to discuss the care plan within 24 hours. We saw evidence in patient notes of discussion with the patient's family.

The Friends and Family Test response rate for medicine at the trust was 33% which was better than the England average of 24% from October 2018 to September 2019.

Friends and family Test – Response rate between October 2018 to September 2019 by site

The data in the table below shows between 85-97% of patients who have used the service would recommend it to their friends and family if they needed similar care and treatment. This data shows that in general patients are happy with the care they have received at the service.



Ward name	Total Resp ^{1,2}	Resp. Rate	Percentage recommended ³												Annual perf ¹
			Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Oct-19	
MCGILL AMU IP	1,075	23%	90%	88%	92%	89%	93%	92%	90%	93%	96%	93%	95%	84%	91%
CCU IP	943	47%	97%	98%	98%	96%	98%	99%	99%	96%	100%	96%	96%	94%	97%
BAEC	755	29%	100%	99%	97%	98%	100%	100%	93%	97%	100%	99%	100%	98%	99%
AAU IP	630	24%	86%	87%	92%	86%	90%	85%	94%	86%	95%	97%	98%	95%	91%
E3 IP	383	42%	88%	93%	92%	100%	97%	90%	94%	97%	97%	97%	93%	88%	95%
FRESHFIELD IP	310	68%	100%	94%	94%	91%	97%	100%	91%	97%	96%	97%	88%	96%	95%
E1 IP	295	38%	96%	100%	90%	96%	94%	87%	100%	95%	100%	95%	100%	93%	96%
CLIFTON IP	274	50%	96%	100%	100%	95%	100%	100%	97%	96%	100%	100%	83%	100%	98%
VICTORIA IP	268	27%	86%	100%	86%	100%	84%	100%	98%	96%	95%	95%	94%	90%	94%
ST CROSS IP	260	34%	100%	98%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	99%
F1 IP	257	62%	100%	88%	80%	79%	100%	100%	96%	100%	95%	100%	100%	100%	96%
E4 IP	246	28%	100%	97%	92%	87%	96%	96%	100%	100%	100%	90%	100%	93%	96%
F3 IP	218	63%	100%	92%	100%	100%	95%	78%	97%	95%	96%	100%	92%	96%	95%
WAINWRIGHT IP	214	41%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	93%	100%	87%
CLARKE IP	212	28%	88%	86%	100%	97%	100%	100%	100%	96%	100%	100%	100%	100%	89%
EIW IP	208	65%	94%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	99%
WESSEX WX IP	150	39%	100%	91%	100%	100%	100%	100%	100%	100%	92%	100%	90%	100%	97%
KINGFISHER IP	147	68%	90%	100%	94%	100%	100%	75%	100%	100%		100%	95%	94%	95%
E2 IP	129	22%	100%	94%	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%	85%
F2 IP	104	46%				90%	100%	83%	88%	100%	85%	100%	80%	96%	87%

Key Highest score to lowest score
 100% 50% 0%

- The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
- Sorted by total response.
- The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Patients were admitted to the wards by referral from their general practitioner or from the

emergency department.

The service met the needs of individuals with long term conditions. For example, the service ran a day case unit for infusions. Appointments were organised with consideration for the patient, the service staggered appointments so that patients would not be waiting around for longer than they needed to. The day case unit was relaxing and comfortable for patients, the manager of the unit told us this was intentional and that because these patients are frequently at the unit with long-term conditions the unit wanted to avoid making it feel like a hospital for the patient. The unit was friendly, chairs were comfortable, and the unit was open and social.

The acute assessment unit had one section for frailty admissions and the other side for enhanced care. The frailty unit provides specialist care for older people. The acute assessment unit was open 24 hours a day, seven days a week to take admissions. Patients would be admitted following general practitioner referral or through the emergency department. We were told the acute assessment unit helped to relieve pressures in the emergency department.

The service had a rehabilitation unit, Overton unit. Patients on this unit are supported with the transition from hospital care towards care in the community.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had prompt access to mental health liaison, learning disability advice, dementia support and elderly mental health services. Patients could access specialist advice from outside the hospital if their condition required it. For example, staff told us an example of one patient on their ward who had been sent to a hospital in London for specialist neurological assessment.

Managers planned and organised services, so they met the changing needs of the local population. The service worked with local organisations to organise and plan care for patients once they had left hospital. The service was proactive around arranging care packages for patients in hospital and for those patients who were leaving their care. The service worked hard to ensure patients were in the place best for their care needs. In one case, staff had a patient who had been sectioned under the Mental Health Act, the patient was medically fit for discharge and staff were waiting for the patient to have a confirmed bed in a mental health unit in another hospital.

Facilities and premises were appropriate for the services being delivered. The hospital had good transport links for patients and relatives. Signage in the hospital was easy to follow.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

During our inspection we noted information leaflets for patients and relatives which were written in a way they could understand.

The service did not have information leaflets available in languages spoken by the patients and local community. During our visit we did not see any information leaflets available in languages other than English. Staff said they could access translation services if needed so leaflets could be made available in other languages. We were not told of any delays in translation services.

We were told by staff that the service could access translation services to assist with communication.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access interpreters and signers for patients if they needed it, we were not told of any delays in interpreter services.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff made sure patients living with mental health problems received the necessary care to meet all their needs. Staff were understanding and kind to all patients and showed patients living with mental health problems the same care and treatment.

Staff could access additional support and advice from liaison teams within the hospital. Staff could access the mental health liaison team 24 hours a day seven days a week.

The trust had a learning disability team. The learning disability liaison team were available Monday to Friday 9am to 5pm.

The service referred to the learning disability team for advice and support. For example, the team review where the best place is for the patient to stay. Staff told us they received adequate and timely response to referrals to specialist teams.

Staff understood and applied the policy on meeting the information and communication needs of patients with a learning disability.

Staff could use tools to help communicate with patients with learning disabilities including: a disability distress assessment tool and a pain assessment tool.

Staff made sure patients living with dementia received the necessary care to meet all their needs. The dementia team work to support patients, relatives and carers and are available Monday to Friday 7am to 7pm.

Wards were designed to meet the needs of patients living with dementia. Elderly care wards were dementia friendly, the wards had colour distinction of doors, windows, walls and railings to help dementia patients. Bright colours and high-contrast can help dementia patients with depth perception and orientation. Elderly care wards had puzzles on the walls and posters with advertisements from a time relevant to the elderly patients on the ward.

Patients on wards F2 and F3 benefitted from the 'Sunflower Suite' which had objects familiar to elderly patients such as a type writer. The Sunflower Suite also contained a computer system which patients could play a large variety of music and play memory games.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff encouraged use of 'This is me' documents a hospital passport which includes: "things you must know about me", "things that are important to me" and "my likes and dislikes". These documents help staff with information about the patient with learning disabilities.

Staff understood and applied the policy on meeting the information and communication needs of patients with sensory loss.

We were told by staff that they could print out information for patients in large font to assist patients with sight impairment.

Wards were designed to have bright colours to help with distinction of doors, windows and walls. Designs helped patients with sight loss.

The service had links with the local council adult services for individuals with sensory loss and they could direct patients for advice.

Patients who were disabled were supported using disabled toilets, hoists and mobility aids. The ward areas had wheelchair access.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed staff asking for patient food and drink preferences on admission. Patients were given a choice of food and drink and staff supported them to choose.

Patients could reach call bells and staff responded quickly when called. During our visit we observed staff responding promptly to call bells. Patients commented that staff respond quickly to call bells and we saw evidence of call bells in easy reach.

Patients with special needs were discreetly identified on the ward using magnetic symbols above the patient's bed.

Access and flow

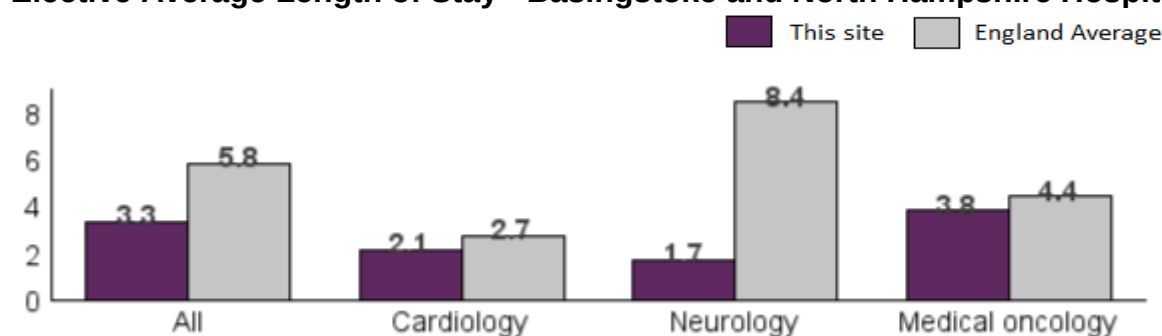
People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

From July 2018 to June 2019 the average length of stay for medical elective patients at Basingstoke and North Hampshire Hospital was 3.3 days, which was lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 6.3 days, which was higher than England average of 6.0 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology was lower than the England average
- Average length of stay for elective patients in neurology was lower than the England average
- Average length of stay for elective patients in medical oncology was lower than the England average
- average

Elective Average Length of Stay - Basingstoke and North Hampshire Hospital



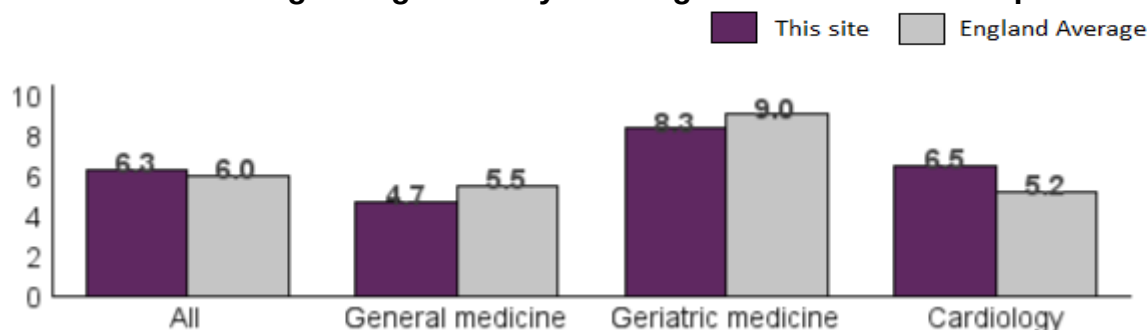
Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine was lower than the England average

- Average length of stay for non-elective patients in geriatric medicine was lower than the England average
- Average length of stay for non-elective patients in cardiology was higher than the England average

Non-Elective Average Length of Stay - Basingstoke and North Hampshire Hospital



Note: Top three specialties for specific site based on count of activity.

Referral to treatment (percentage within 18 weeks) – by specialty

Seven specialties were above the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
General medicine	100.0%	96.3%
Geriatric medicine	100.0%	96.5%
Thoracic medicine	100.0%	93.9%
Rheumatology	99.2%	94.3%
Neurology	98.9%	88.8%
Gastroenterology	97.9%	92.1%
Cardiology	89.4%	80.5%

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Dermatology	65.7%	80.2%

(Source: NHS England)

Patient moving wards per admission

The service moved patients only when there was a clear medical reason or in their best interest. Staff did not move a patient unless in their best interest and they felt their care would be managed better in another setting.

From October 2018 to September 2019, within the top five medical wards at the trust, 82.3% of patients did not move wards during their admission and 17.7% moved once or more. The highest percentages of patients moving wards once or more were within wards F3 (26.7%), F2 (24.2%) and F1 (18.3%) all located at Basingstoke and North Hampshire Hospital.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From October 2010 to September 2019, there were 97 patient moving wards at night within medicine. The highest number of ward moves at night, at Basingstoke and North Hampshire Hospital, was reported for wards F2 (24) and F3 (19).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Staff did not often move patients between wards at night. Staff aimed to keep bed moves at night to a minimum and only in the case of a medical emergency. Out of hours bed moves was reported as an area of focus for the medical division.

For patients who are being transferred to community, primary and social care settings the hospital had a dedicated site team who made calls to external bodies to facilitate discharges, where possible. The trust had a complex discharge team who worked Saturday and Sunday to maximise weekend discharges.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff routinely discussed planned discharge date as soon as a patient entered the wards; we saw ward notice boards with planned discharge dates. Discharge dates were readjusted following board meetings each day. From board meeting observations we saw staff discussed discharges and what needed to be done to progress them. Staff worked with the complex discharge team to try and get patients discharged before midday. The hospital had patient flow coordinators who visited wards daily to support staff with patient discharge and flow in the hospital.

The hospital had a discharge lounge open Monday to Friday 8am to 8pm. The discharge lounge was used to help with patient discharge earlier in the day and release bed capacity in the hospital.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff worked in multidisciplinary teams to plan discharges carefully. Discharge pathways were discussed as a multidisciplinary team in daily board meetings, patients are allocated a discharge pathway number according to patient needs. Staff in these meetings discussed discharge updates and used coloured magnets to indicate stage of discharge. For example, a red magnet would indicate that there was something that needed to be done this magnet was replaced with a green magnet when the task was complete.

Managers and staff worked to make sure patients did not stay longer than they needed to. Managers knew patients who were medically fit for discharge and worked hard to make sure these patients did not have to stay longer than they needed to. Staff told us the main issue delaying patients discharge was waiting for domiciliary care packages to be available. This was corroborated by data the trust sent us, which indicated that the highest proportion of delayed discharges were due to domiciliary care packages not being in place.

Managers monitored the number of delayed discharges, knew which wards had the highest number and acted to prevent them. Ward managers monitored delayed discharges and reported them. The hospital had undertaken work with an external provider to improve patient flow. It was reported that initially this work had shown a positive effect in the emergency department, but flow had not improved elsewhere in the hospital yet.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Managers worked to minimise the number of medical patients on non-medical wards. At the time of inspection, the hospital had a dedicated medical outliers' team to assess patients on wards which were not best suited for their care needs. This meant that it gave the medical staff more time to assist on the wards. Medical staff said they benefitted from a dedicated medical outlier team and they thought it worked effectively. Clinical matrons discussed if their

patients would be suitable for other wards during safety huddles, this was to free up beds to minimise the number of medical patients on non-medical wards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. During our visit we saw information clearly displayed on ward informing patients how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff aimed to resolve any complaints with the patient or relative whilst they were on the ward. If the complaint could not be resolved in person staff referred the complaint to the Patient Advice and Liaison Service (PALS). We saw this during our inspection: a relative of a patient had come in to collect their relative for discharge. The relative became frustrated because the patient could not be discharged because they were waiting for pharmacy medicines. We saw staff explaining the situation to the relative, calming them down and offering reasonable solutions to the relative's complaint. The complaint was dealt with in a professional and compassionate manner.

Managers investigated complaints and shared feedback from complaints with staff and learning was used to improve the service. The service had a high percentage of complaints around staff communication. During our inspection we saw notice boards in several wards with a focus on how to improve communication between staff and patients. Learning and actions of the ward staff could be seen on the board for example the service encouraged doctors to communicate more effectively with the patient during the ward round.

Staff could give examples of how they used patient feedback to improve daily practice. We observed "You said, we did" notice boards in wards. These boards highlighted examples of patient feedback taken to improve the service. In one example a patient told the service that they did not feel fully informed about the process involved in their discharge, the learning presented in this case was around continually communicating about discharge as a team, which will result in clearer communication with the patient.

From October 2018 to September 2019, there were 82 complaints about medicine at Basingstoke and North Hampshire Hospital. The hospital took an average of 23 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be investigated and closed within 25 working days. A breakdown of complaints by type is below:

Type of complaint	Number of complaints	Percentage of total
Communication	27	32.9%
Patient care	13	15.9%
Clinical treatment	12	14.6%
Admissions and discharges	9	11.0%
Values and behaviour	9	11.0%
Prescribing	4	4.9%
Access to treatment and drugs	2	2.4%
Appointments	2	2.4%

Trust admin/policies/procedures	2	2.4%
Facilities	1	1.2%
PDW	1	1.2%
Total	82	100.0%

Number of compliments made to the trust

From October 2018 to September 2019 there were 60 compliments about medicine at the trust. A breakdown of compliments by site is below.

Site	Number of compliments	Percentage of total
Basingstoke and North Hampshire Hospital	25	50.0%
Royal Hampshire County Hospital	25	50.0%
Total	50	100.0%

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

Is the service well-led?

Leadership

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

The medical division senior leadership team had the appropriate skills, knowledge and experience to fulfil their role in running the service. The trust developed its leaders through its leadership development strategy program. This program developed staff at all levels of leadership. For example, for new managers the trust offers development courses in 'difficult conversations' and 'ready to lead'. For members of staff aspiring to be in executive roles the trust offers a clinical director's program.

There were clear structures and lines of accountability within the medical division and all staff knew who they reported to. For example, staff working on a ward reported to the clinical matron who ran the ward. The clinical matron for each ward reported to the clinical director specific for the ward they ran. The clinical directors reported to the operations directors; who reported to the medical director on the executive team.

Staff on the wards felt supported by their managers. Managers were accessible and adopted an 'open door' policy.

Leaders understood priorities and issues the service faced and managed them. For example, the catheter laboratory was always working at full capacity and demand was high. The catheter laboratory was on the medical division's risk register because the equipment was old and beyond its length of service. Managers had identified this as a risk and acted to build new facilities.

The trust had adopted a strategy for hiring clinical matrons to run each ward. The clinical matrons we spoke with during our inspection told us they enjoyed their role. Clinical matrons had ward management responsibilities, whilst also contributing clinically to how the ward ran. Clinical matrons felt that they were informed and could contribute more effectively in discussions with

senior leadership because they worked clinically in the wards. Medical juniors felt supported by senior consultants and told us they were approachable.

Most staff told us they did not feel presence on the wards from the executive team within the hospital and that they had never met them. However, we were given examples of the executive team making a conscious effort to recognise the hard work of the staff in the acute assessment unit. For example, we were told that the executive team did a hot chocolate run for the staff working the night shift during the Christmas period in the acute assessment unit. Similarly, in the summer the executive team brought ice lollies for staff to the unit.

Vision and strategy

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

The trust had an overall vision to 'provide outstanding care for every patient'. The stakeholders involved in the vision were the patients and the staff that provide the care. The trust strategy, to achieve the overall vision of 'outstanding care for every patient', included: outstanding care for patients, empowering people, living within their money and innovating for the future.

The strategy objective 'outstanding care for patients' focused on meeting national standards, implementing quality improvement and meeting the trusts 'CARE' values. The trusts CARE values are: compassion, accountable, respect and encouraging. The strategy objective 'empowering people' focused on creating a collaborative culture where staff can provide outstanding care. The strategy objective 'living within our money' focused on sustainability of services. The trust sets out to achieve this target by meeting financial targets, investing in staff, equipment and estates and finding smarter ways to fund development. The strategy objective 'innovating for the future' focused on delivering transformational clinical care using technology.

During our inspection we spoke with the leadership team for the medical division and they told us that since the last inspection they are pleased with the progress towards giving outstanding care to patients and improvement and innovation. The trust set targets to achieve each strategy objective and monitored progress of each strategy objective towards achieving the overall trust vision.

During our visit we saw the vision and strategy of the medical division specifically to each ward displayed in the ward areas. Staff were aware of the vision and strategy and how this applied to them in their role. The vision had been fed through to staff level, staff told us they felt that the care they gave was outstanding and compassionate.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

The trust had implemented work on developing culture in the service by developing leaders to reflect cultural values. The senior leadership team in the medical division expressed that this work had affected the culture within the service.

Staff were given opportunities for career development and supported in doing so. For example, we spoke with one healthcare assistant who was being supported to train to be a nurse. The service had a leadership development program to support staff who wanted to become leaders and managers.

Staff felt valued, supported and respected in their roles and felt proud to work for the trust. Results from the staff survey showed that staff felt able to make suggestions to improve ways of working.

Staff consistently told us that care was focused on the patient and the best part of their job was to see patients get better. Results from the staff survey indicated that staff felt satisfied with the quality of care they gave to patients.

There was a strong emphasis on staff wellbeing and managers monitored and discussed wellbeing with their staff. This was corroborated by positive staff survey responses to the question: 'My immediate manager takes a positive interest in my health and wellbeing'. Staff work as a collaborative team, share responsibility and avoid conflict if there are differing ways of working.

The teams were caring and compassionate in their interactions with each other and during our inspection we observed excellent team moral and support. Results from the staff survey indicated that relationships at work were not strained.

Managers were open and encouraged concerns to be raised. Results from the staff survey showed that staff know how to report unsafe practices and concerns and felt secure raising these issues. Further results showed that staff were confident that the trust would address the concern which was raised.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medical division held divisional governance board meetings, attendees included; director of medical services, operations directors and deputies, divisional chief nurse, clinical directors, clinical leads, governance leads, finance manager, head of unscheduled care, operational services manager, nurse managers and clinical matrons.

We saw meeting minutes for the last three governance meetings, which were comprehensive. Divisional governance meetings were held quarterly. Discussions in these meetings focused on: standing items, items for discussion, items for decision, items for information and shared learning. Meeting minutes showed that discussions and reports from other governance groups were agenda items in the divisional governance meeting. Information from other divisions in the hospital were also discussed in divisional governance board meetings if learning could be shared.

Leaders maintained effective governance processes. Staff had regular meetings to discuss performance and learn from each other. Staff are given protected time for divisional governance activities. Meeting minutes were available on a shared drive, so all staff could access the minutes and read about learning.

There were mortality and morbidity meetings every month where lessons learnt and improvements that should be implemented were fed back to staff. Recorded meeting minutes from mortality and morbidity meetings showed discussion of incidents, how they were investigated and what learning needed to be shared with teams. Hospital mortalities are reviewed by consultants who are

independent and from another specialty. The trust was looking to take on a medical examiner to take on all mortality reviews.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Performance in the medical division was reviewed by senior leadership during monthly performance review meetings. We saw minutes from the medical division performance review meetings, these meetings discussed the following: governance, performance, finance and the workforce. Actions were documented against an individual's name and progress was reviewed in the following months meeting and followed up appropriately. The minutes from these meetings were comprehensive and covered issues discussed at ward to board level.

Quality and safety performance were monitored using quality indicators which were presented in a medical division scorecard. This included 'headline' information, 'key driver' information and 'corrective actions'. The scorecard also included the divisions financial performance. The scorecard is presented in the board report to the senior leadership team. This meant the leadership team had up-to-date information on the division's safety performance and financial performance.

Managers were aware of the risks and challenges to the service. Managers were proactive in acting to address them. For example, the main challenges to the service were staffing and flow. Staff and flow discussions occurred daily, and managers were focused on these. Managers were actively recruiting more staff and focused on staff retention through engagement.

There was effective risk oversight by leaders higher up in the organisation, this reflected and aligned with what staff saw as their risks. The trusts board assurance framework aligned with risks identified in the medical division risk register. Risks are reviewed regularly, and actions updated.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service collected data at ward level through reporting systems. Managers had access to a range of information to support them in their role, understand performance and make decisions.

Staff had access to electronic records that they could update. For example, managers could monitor performance through assurance reports and the performance dashboard. All staff could access shared documents, this was to allow staff to read meeting notes and share learning amongst teams.

Staff had no difficulties accessing systems to gain information. However, some staff said they felt IT systems could be more integrated to work more effectively. On inspection we saw staff were occasionally confused where different patient records were held as some assessments were in patient bedside notes and other assessments held on the computer. Staff had enough access to computer terminals, all of which were password protected and would lock with inactivity.

Staff received training on information governance as part of their mandatory training. Staff understood how to report information governance breaches.

Staff had easy access to comprehensive and up-to-date information on patients care and treatment. Medical staff prescribed medicines using an e-prescribing system, only one staff member could access a patients file at any one time. This was to ensure medicines were not being recorded by multiple staff at the same time; which can lead to medicines errors.

Engagement

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

The trust outlined an action plan following the staff engagement survey. Actions were centred around empowering staff through active engagement and with the intention of improving staff retention. The engagement plan was to increase the visibility of the leadership team through better information communication.

Engagement plans also focused on celebrating department and staff successes and achievements within the medical division. Staff felt they were engaged with the service through daily team meetings, for example, board rounds and safety huddles and a monthly medical division newsletter which outlined key developments and updates.

Patient engagement was a key priority for the trust. We saw the trust held workshop with staff, the local CCG and patient representatives. The workshop aimed to engage with patients, staff, equality groups, the public and local organisations create an engagement strategy and improve services for patients. The trust was aiming to produce a strategy in the coming months to outline what the medical division's commitments were to this strategy.

Learning, continuous improvement and innovation

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

Senior leadership encourage staff to improve the service and all staff could apply to be a quality improvement agent. For example, the divisional quality improvement strategy promotes "Everyone is an improver". We saw quality improvement projects taking part at ward level, for example outside of F1 ward they had a notice board showing ongoing projects. Quality improvement projects outside F1 ward included communication and constipation.

The trust had a quality improvement programme, overseen and supported by the governance team. Steering groups fed into the quality improvement program. An example of a quality improvement steering group at the hospital was the innovation steering group.

The hospital had a team of researchers involved in clinical trials in the hospital. The hospital had recently been recognised for its collaborative working to deliver a research study on ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and the medical division was actively involved in this research.

Surgery

Facts and data about this service

Hampshire Hospitals NHS Foundation Trust

The hospital provides a full range of planned and emergency services, including a 24-hour accident and emergency, general and specialist surgery, general medicine, intensive care, rehabilitation, chemotherapy, diagnostic services, maternity, neonatal, gynaecology, paediatric care and outpatient clinics.

Basingstoke and North Hampshire Hospital (BNHH) provides some specialist services to people across the UK and internationally. They are one of two centres in the UK treating pseudomyxoma peritonei (a rare form of abdominal cancer) which spreads cancerous cells to the lining of the abdominal cavity (the peritoneum). Several types of tumour including non-cancerous ones can cause pseudomyxoma peritonei. The hospital provides tertiary liver and colorectal cancer services as well as the haemophilia service.

The trust runs a range of surgical services for inpatient and day case procedures including urology and peritoneal malignancy as well as services for hepatobiliary, upper gastrointestinal, colorectal, ENT, ophthalmology, orthopaedics, oncology, maxiofacial and oral surgery.

Basingstoke and North Hampshire Hospital

Basingstoke and North Hampshire Hospital hosts the Peritoneal Malignancy Unit for the treatment of pseudomyxoma peritonei (a rare form of abdominal cancer). Additionally, the hospital has a Diagnostic Treatment Centre (DTC), four endoscopy rooms, seven operating theatres, the Eye Day Care Unit (EDCU) with one eye theatre (local anaesthetic cases only) and a pre-assessment unit. The surgical division at this site has the following wards and units:

Ward/unit	Number of beds	Services provided
Ward C2	18	Liver and peritoneal malignancy
Ward C3	21	Non-elective surgery
Ward C4	22	Elective surgery
Ward D1	33	Elective orthopaedic
Ward D3	24	Orthopaedic trauma
Ward D4	22	Orthopaedic trauma
Woman's health unit	10	Breast surgery and gynaecology
Diagnostic treatment centre	12	Day treatment centre
Total	162	

The trust had 36,223 surgical admissions from July 2018 to June 2019. Of these, 10,620 (29.3%) were emergency admissions, 20,105 (55.5%) were day case, and the remaining 5,498 (15.2%) were elective.

(Source: Hospital Episode Statistics)

During this inspection we visited the following wards/units across surgical services.

- C2- Liver and peritoneal malignancy ward
- C3 – Non-elective surgery ward
- C4- Elective surgery ward
- EDCU- Emergency day care unit
- D1-Elective orthopaedic ward
- D3- Orthopaedic traumas ward
- D4- Orthopaedic trauma ward
- Day Treatment Centre
- Eye day care unit
- Operating theatres.

Our inspection was unannounced, people did not know we were coming. The inspection team spoke with 16 patients and their relatives, approximately 24 members of staff including nurses, doctors, health care assistants, specialist nurses, allied healthcare staff such as physiotherapists and pharmacist, receptionists, and domestic staff. We observed care and treatment and reviewed 14 patients' records. We also reviewed information, documents and data provided by the trust both before and after the inspection.

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however not all staff had completed the required training.

Mandatory training completion rates

A breakdown of compliance for mandatory training courses from April to September 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Counter fraud	463	475	97.5%	90%	Yes
Dementia awareness (including privacy and dignity standards)	462	475	97.3%	90%	Yes
Equality and diversity	453	475	95.4%	90%	Yes

Health and safety (slip, trips and falls)	453	475	95.4%	90%	Yes
Conflict resolution	434	475	91.4%	90%	Yes
Moving and handling	429	475	90.3%	90%	Yes
Information governance	434	475	91.4%	95%	No
Fire 1 year	423	475	89.1%	90%	No
Basic life support	365	429	85.1%	90%	No
Immediate life support	365	429	85.1%	90%	No
Infection control	360	475	75.8%	90%	No
Medicine management training	252	475	53.1%	90%	No

In surgery the 90% target was met for six of the 12 mandatory training modules for which qualified nursing staff were eligible. Nursing staff did not meet the 90% target set for the key modules such as infection control, medicines management training, basic life support and immediate life support.

A breakdown of compliance for mandatory training courses from April to September 2019 at trust level for medical staff in surgery is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality and diversity	240	296	81.1%	90%	No
Health and safety (slips, trips and falls)	239	296	80.7%	90%	No
Moving and handling	228	296	77.0%	90%	No
Conflict resolution	227	296	76.7%	90%	No
Counter fraud	214	296	72.3%	90%	No
Dementia awareness (including privacy and dignity standards)	201	296	67.9%	90%	No
Basic life support	200	296	67.6%	90%	No
Immediate life support	200	296	67.6%	90%	No
Fire 1 year	200	296	67.6%	90%	No
Infection control	193	296	65.2%	90%	No
Information governance	151	296	51.0%	95%	No
Medicine management training	14	296	4.7%	90%	No

In surgery the 90% target was not met any of the mandatory training modules for which medical staff were eligible. Medical staff did not meet the 95% target set for the module information governance.

Although medical staff received training, they did not keep up-to-date with their mandatory training. A senior staff told us that medical had difficulty in completing face to face training due to workload and patients' acuity. Staff told us this had been more difficult since the changes in trauma orthopaedic and managers were looking into this and how to support them.

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

Basingstoke and North Hampshire Hospital

Nursing staff received and kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2019 for qualified nursing staff in surgery at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				Target met (Yes/No)
	Staff trained	Eligible staff	Completion rate	Trust target	
Dementia awareness (including privacy and dignity standards)	275	282	97.5%	90%	Yes
Counter fraud	273	282	96.8%	90%	Yes
Equality and diversity	268	282	95.0%	90%	Yes
Health and safety (slips, trips and falls)	265	282	94.0%	90%	Yes
Conflict resolution	260	282	92.2%	90%	Yes
Moving and handling	259	282	91.8%	90%	Yes
Information governance	259	282	91.8%	95%	No
Fire 1 year	249	282	88.3%	90%	No
Basic life support	232	265	87.5%	90%	No
Immediate life support	232	265	87.5%	90%	No
Infection control	211	282	74.8%	90%	No
Medicine management training	153	282	54.3%	90%	No

In surgery the 90% target was met for six of the 12 mandatory training modules for which qualified nursing staff at Basingstoke and North Hampshire Hospital were eligible. Nursing staff did not meet the 95% target set for the module information governance.

The clinical lead told us that compliance with mandatory training was monitored and staff were reminded they needed to complete the required training. The staff were allocated one to two hours to complete mandatory training. However, we were told that releasing staff from the wards for training was difficult at times due to staff shortages, although staffing was improving.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Nursing staff told us they were encouraged to undertake training and managers monitored mandatory training and clinical leads alerted staff when they were out of compliance with training.

Theatre staff were compliant with mandatory training and staff were supported to undertake specific training to maintain their skills and meet their revalidation requirements. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the professional registers.

A breakdown of compliance for mandatory training courses from April to September 2019 for medical staff in surgery at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)

Equality and diversity	140	170	82.4%	90%	No
Health and safety (slips, trips and falls)	133	170	78.2%	90%	No
Moving and handling	127	170	74.7%	90%	No
Conflict resolution	125	170	73.5%	90%	No
Basic life support	119	170	70.0%	90%	No
Immediate life support	119	170	70.0%	90%	No
Fire 1 year	119	170	70.0%	90%	No
Counter fraud	117	170	68.8%	90%	No
Dementia awareness (including privacy and dignity standards)	116	170	68.2%	90%	No
Infection control	110	170	64.7%	90%	No
Information governance	81	170	47.6%	95%	No
Medicine management training	5	170	2.9%	90%	No

In surgery the 90% target was not met for any mandatory training modules for which medical staff at Basingstoke and North Hampshire Hospital were eligible. Medical staff did not meet the 95% target set for the module information governance.

A senior staff told us that medical had difficulty in completing face to face training due to workload and patients' acuity. Staff told us this had been more difficult since the changes in trauma orthopaedic and managers were looking into this and how to support them.

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The 90% target was met for safeguarding adult and children level one training modules for which qualified nursing staff in surgery at Basingstoke and North Hampshire Hospital were eligible.

Staff including nurses, allied healthcare professionals and junior doctors could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns that may affect the welfare of patients under their care.

Following the inspection, we requested data on medical, nursing and allied healthcare staff's compliance with Level 2 safeguarding training compliance. The trust provided us with the latest data for December 2019 showed this was below the trust compliance rate of 90%, nursing staff were at 74% and medical staff at 49%. This may impact on patients as staff may not have the up to date information to support their practice.

The trust had safeguarding team leads who were available for staff, patients and relatives to contact for advice. The safeguarding leads also provided a response where harm or abuse had occurred and worked with other agencies such as social services and the police to promote patients' safety.

The wards and other areas displayed safeguarding information and including details of the trust's safeguarding team and how to contact them.

The surgical team made 68 safeguarding adult referrals in the inspection reporting period, between January to December 2019. Staff told us that PREVENT training was part of the trust mandatory training programme. PREVENT raises awareness to stop individuals from getting involved or supporting terrorism or extremist activity.

Safeguarding training completion rates

Nursing staff received training specific for their role on how to recognise and report abuse.

The trust set a target of 90% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April to September 2019 at trust level for medical staff in surgery is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	207	296	69.9%	90%	No
Safeguarding children (level 1)	190	296	64.2%	90%	No

In surgery the 90% target was not met for either of the safeguarding training modules for which medical staff were eligible.

Basingstoke and North Hampshire Hospital

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from April to September 2019 for qualified nursing staff in surgery at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding children (level 1)	270	282	95.7%	90%	Yes
Safeguarding adults (level 1)	266	282	94.3%	90%	Yes

A breakdown of compliance for safeguarding training courses from April to September 2019 for medical staff in surgery at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019

	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults (level 1)	109	170	64.1%	90%	No
Safeguarding children (level 1)	106	170	62.4%	90%	No

Medical staff received training specific for their role on how to recognise and report abuse. However; medical staff did not always keep up to date with safeguarding training. The 90% target was not met for either of the safeguarding training modules for which medical staff in surgery at Basingstoke and North Hampshire Hospital were eligible. It was unclear from speaking to the staff how the trust ensured medical staff training was monitored. Junior doctors told us they would discuss any safeguarding concerns with the consultants or the nurse in charge and necessary actions would be taken.

Following the inspection, we requested data on medical staff's compliance with Level 2 safeguarding training. Data received showed low compliance, where medical staff achieved 47% training for level 2 in safeguarding which was below the trust compliance rate of 90%.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All the ward areas were clean and had suitable furnishings which were clean and well-maintained. We found the surgical unit was visibly clean and tidy and in good state of repair. The patients told us the standards of cleanliness was good.

The staff in the surgical wards followed their infection control procedures and used side rooms for isolating patients, if patients had or were suspected of having an infectious condition. Staff kept visitors and relatives informed on procedures they needed to follow such as use of personal protective equipment when accessing the isolation areas to minimise the spread of infection.

Between January and December 2019, the surgical division had no cases of healthcare acquired infection *Methicillin-resistant Staphylococcus aureus* (MRSA).

Procedures had been developed to assess patients and they were routinely screened for MRSA, as part of their pre-operative process. Staff followed the trust's procedures, including routine testing of susceptible patients in line with best practice guidelines.

There were nine cases of clostridium difficile (C. Diff) and three cases of Methicillin-sensitive *Staphylococcus aureus*, (MSSA).

The trust took part in Patient-led assessment of care environment (PLACE) assessments. These were annual appraisals and assessment of the environment and supported the provision of care. Areas looked at include cleanliness, food and hydration, privacy, dignity and wellbeing, condition appearance and maintenance, dementia, and disability. Results from this assessment were published by the NHS health and social care information centre and on the trust's website. The PLACE scores varied between 69% and 98%.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed guidelines such as bare below the elbow procedures were followed in clinical areas.

Staff adhered the five moments of hand washing in line with the world health organisation protocols to prevent the spread of infection. Hand wash basins were available in the bays.

We saw staff cleaned equipment and the bed space after each patient to minimise the risks of cross infection. Staff labelled equipment with 'I am clean' stickers to show when it was last cleaned. This process gave assurance to staff that equipment were clean and ready for use. Visitors to all wards were encouraged to clean their hands upon entry and exit. Hand sanitiser stations were clearly signposted next to access doors.

The service carried out regular handwashing and cleaning audits to assess staff's compliance with infection control practices. The service undertook a re-audit at six-month intervals for any areas of non-compliance. The environmental audits for C4 in August 2019 scored 94% although there was no cleaning schedule developed as recommended after the last audit. The re audits for D3 in October 2019 and D4 in November 2019 scored 90 and 92%. An action plan had been developed to achieve compliance.

We reviewed the audit results for wards C1, C2, C3 and the Day Treatment Centre. Hand hygiene results ranged between 97% and 100%, and cleanliness audits scores were between 94% and 97%. The latest results were displayed at the entrance to the wards. The results were shared with the staff and an action plan to achieve compliance was developed in line with the trust's target.

There were two operating theatres with laminar flow (laminar flow is a system of circulating filtered air to reduce the risk of airborne contamination). This worked to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments.

Staff followed good practice guidance and their internal procedures for maintaining clean and dirty flow within operating theatres. This included limiting the number of staff entering the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum. There was an effective facility for the sterilisation of surgical instruments. Theatre staff told us there were no problems obtaining instruments in a timely way for procedures.

Environment and equipment

The design, maintenance and use of facilities, premises kept people safe. Staff were trained to use them. Staff managed clinical waste well. Staff did not always check the emergency equipment to ensure they were safe and ready for use.

The design of the environment followed national guidance and the premises were well maintained and in good state of repair. Consideration was given for people with limited mobility and wheelchair users with ramps and level access provided. There were adequate and suitable seating in the day treatment centre, including chairs and couches as appropriate.

The wards designated bays for male and female patients including washing and toilet facilities to meet patients' needs and compliance with mix sex breaches. Staff told us there were clear processes for mix sex breach and the surgical services monitored and reported on this. There were very low incidents of a breach in surgical wards except for one case in November 2019, in the day surgery ward. The trust reported this in line with their mix sex breach.

Staff on the wards mostly carried out daily safety checks of specialist equipment, however in the operating theatres these were fully completed. The service had enough suitable equipment to help them to safely care for patients.

The resuscitation trolleys contained tamper evident tags, and these were checked on C3, the day treatment centre (DTC). A random check of the emergency equipment stored in the resuscitation trolley showed single-use items were sealed and in date. Records of daily checks of resuscitation on the surgical wards, theatres and the day assessment units showed equipment had been checked and was ready for use.

The service could not assure itself that resuscitation trolleys were always checked and ready for use in line with the trust procedures. On wards C2 and C4, we found there were gaps in the records for example on C4 the records showed the daily checks had not been completed on four occasions. On C2 the daily checks were missed on seven occasions and the weekly checks were not carried on 16 and 23 December 2019. Senior staff members we spoke with confirmed that these checks had been missed and actions would be taken to ensure staff adhered to the daily and weekly checks in line with the trust's policy..

The emergency equipment included suction machines which had been serviced recently. Staff told us the suction machine was also included in their daily emergency checks and records were available to confirm this.

The service managed clinical waste well and followed trust's guidelines and in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff disposed of clinical waste safely and these were removed from the dirty clinical rooms at regular intervals to reduce infection control risks. Sharps boxes were available and marked with ward's name and date they were assembled. These were not overfilled, and the lid closed when not in use to prevent risk of accidental exposures or injuries. Sharps boxes were kept on equipment trolleys and used by nurses when attending to patients to ensure safe disposal of sharps.

The service had a process to test electrical equipment providing assurance and ensuring they were safe for use. During the inspection, we checked if electrical equipment had been safety tested, known as portable appliance testing (PAT). We carried out a random check of approximately 26 equipment on the wards and the operating theatres. All had a label indicating the device had been PAT tested and included a due date for retest.

In theatres, the lasers were serviced by the company and the service contracts were looked after by the procurement team. We noted equipment were labelled to show when it was last tested. All items checked had passed an electrical safety test within the last 12 months. In theatre, there was one machine from France used for chemotherapy for colorectal surgery. Staff told us the contractors usually responded within 24 hours for request of servicing.

The service managed substances that were hazardous to health and safety and in line with Control of Substances Hazardous to Health Regulation 2002 (COSHH). These substances were stored securely, and cupboards were locked so cleaning products could not be accessed by unauthorised persons. Staff were aware of the procedures and who to contact in the event accidental exposures to cleaning products.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. National Early Warning Scores 2 (NEWS2), is a recognised tool to identify

deteriorating patients. We reviewed 11 patients' NEWS charts and noted staff recorded observations and calculated early warning scores. Staff had escalated when a patient's NEWS score was high which was in line with national guidance. Staff escalated for urgent medical review where clinically indicated in line with national guidance. A patient who had an increase NEWS score was referred to the critical care outreach team. A review of the patient was completed in a timely manner and plan of actions developed to support the patient such as strict monitoring and their fluids intake and output and blood sugar monitoring.

The service had developed procedures to recognise and respond to sepsis (severe blood infection) in line with national guidance. Sepsis is a rare but serious complication of an infection that can lead to multiple organ failure and death if not treated promptly. The surgical unit had the Sepsis Screening and Action Tool, which staff used when observations triggered sepsis. The service did not have a sepsis box and staff told us they would assemble the necessary items as needed. The staff we spoke with told us they had a list which they followed to assemble the necessary items they needed.

The Surgical unit used the World Health Organisation (WHO) guidelines (5 steps to safer surgery) to ensure patients received their operation safely. The WHO checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks consisted of team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (at the end of the procedure) and debrief. We observed all five steps of the WHO checklist, and saw staff fully completed and engaged in all the required checks. The trust used three different colours WHO checklist according to speciality. We reviewed seven patients' records which showed the WHO checklists were completed.

In the operating theatres, staff used a tracking system, which allowed the tracing of instruments through the department, and to individual patients. The service used the white board where swabs and other items were recorded during the procedure. There was a final check at the end of the procedure to ensure all items and swabs were accounted for. Any discrepancies were addressed prior to the patient leaving the operating theatre. All instruments were also checked against the instrument tray checklist. There were set procedures which staff would follow for any for any missing instrument.

Patients undergoing elective surgery had a pre- assessment completed which was a process to identify patients' suitability for surgery and considering any other pre-conditions that may lead to patients' complications during the anaesthetic, surgery, or post-operative period. Patients were assessed for the risks of venous thromboembolism (VTE, or blood clots). The service acted to reduce identified risks, patients' records showed they had been prescribed anti-coagulants (medicines to prevent blood clots) and compression stockings and boots were used, as clinically indicated to reduce the risk of blood clots. Some patients were also discharged home with anti-coagulants according to their risks.

Between October and December 2019, the trust had 14 incidents of VTE and PEs. All VTE cases were reviewed to see if they might have been avoidable. The findings for this quarter were shown as unavoidable. Action plan was developed which included emails sent to consultants reminding their teams to perform the risk assessment electronically within 24 hours of admission.

Patients admitted for pseudo surgery received elective thromboprophylaxis (medicine to reduce the risk of developing blood clots in blood vessels for high risk patients) in line with the trust guidelines for peritoneal malignancy as these patients were considered as high risk for VTE.

Staff completed risks assessments for patients on admission using recognised tools. These assessments included risks of malnutrition; staff used the malnutrition universal screening tool (MUST) for this assessment. Care plans were developed to manage the risk of malnutrition. However; this was not consistently followed, and care plans for food and fluids management were lacking.

Patients were also assessed for risks of fall using the fall risk assessment tool and pressure damage to skin using the Braden score tool. Care plans were developed using this information to minimise identified risks and were reviewed following any changes.

Patients who were at risks of fall were accommodated in areas where they could be observed. The trust had introduced 'yellow socks' for patients who were at high risks of fall and staff told us this was working well and made it easy to recognise these patients to provide support to them. Records also showed a patient who was at high risks of falls and impaired mobility was referred to the medical team for assessment. Staff followed advice to monitor the patient's postural blood pressure (lying and standing blood pressure monitoring) and records were maintained. Staff were aware of actions they should take to reduce risks of falls and minimise patients' risks.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health (AMSAT). We found staff had taken appropriate action in the day treatment centre (DTC) and had accessed support from the mental health team and the patient received 1:1 support. Staff had arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm.

Staff shared key information to keep patients safe when handing over their care to others. We observed handover of patients in the recovery area. Staff provided a detailed handover which included allergies, drains and dressing, observation and any abnormalities, charts were looked at and amount of fluids given was discussed. Staff also discussed patient's post-op care and any pain control which had been administered. This ensured patients continued to receive safe and consistent care and meet their needs.

Staff in recovery followed their discharge criteria and they told us if this could not be met, they consulted with the anaesthetist and patient was signed off when deemed as stable to leave recovery area. Staff took patients back to the wards and rang the ward first to check it was appropriate to bring the patient back. Staff provided handover over the phone and at the patient's bedside.

The staff told us the recovery area was sometimes used for planned patients such as those who were difficult to extubate. Patients were kept in recovery until they were stable prior to them being transferred to intensive care unit as needed. This ensured patients needing extra care and support were managed safely following their surgery.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers on the wards were carried out at each shift change and information shared effectively. Ward rounds were attended by consultant of the week and the multi- disciplinary team. Each member commented on patients and their progress and on-going care. There were good interactions between all the staff.

Nurse staffing

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

treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The surgical wards displayed their daily staffing compliments in line with the safer staffing. The ward manager discussed staffing levels at handovers and adjusted staffing levels daily according to the needs of patients.

During our inspection we found that actual staffing levels did not always meet the planned levels. There was one member of staff short on some shifts. Staff told us they escalated to bleep holder and they sometimes had support from another ward. Staff said they worked as a team and often they just managed with less staff. Staff told us the wards were busy and they did their best to keep patients safe and it was also dependent on the acuity of patients. Although staff told us they often did not receive extra support when some patients needed 1:1 observations and support as “there was no spare staff and staff shortages”.

Patients we spoke with said they often had to wait for support when they required assistance, and this was mainly at certain times of the day such as morning and evenings. They told us the staff worked very hard and “there was not enough of them to go around”. During the inspection we observed staff were available and responded to call bells in a timely manner.

In theatres, the lead told us staffing had been a challenge and there were six whole time equivalent (WTE) short of qualified nurses. They planned to have four new starters in February/ March 2020 which included UK and overseas staff. Theatre staffing was in line with the Association for Perioperative Practice guidance and lists were covered. The Association for Perioperative Practice (AFPP) recommended minimum theatre staffing levels of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner for each theatre list. We observed that theatre staffing met these recommendations and a senior staff told us they often staffed the operating lists with an extra circulating member. The staff told us they worked as a team and used their bank staff and block booked agency staff to promote consistency in care.

Trust level

The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust’s targets, where applicable:

Surgery annual staffing metrics							
October 2018 to September 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	1,241	9%	18%	3.7%			
Qualified nurses	496	16%	9%	4.4%	86,654 (9%)	40,457 (4%)	19,055 (2%)

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

Basingstoke and North Hampshire Hospital

The table below shows a summary of the nursing staffing metrics in surgery at Basingstoke and North Hampshire Hospital compared to the trust's targets, where applicable:

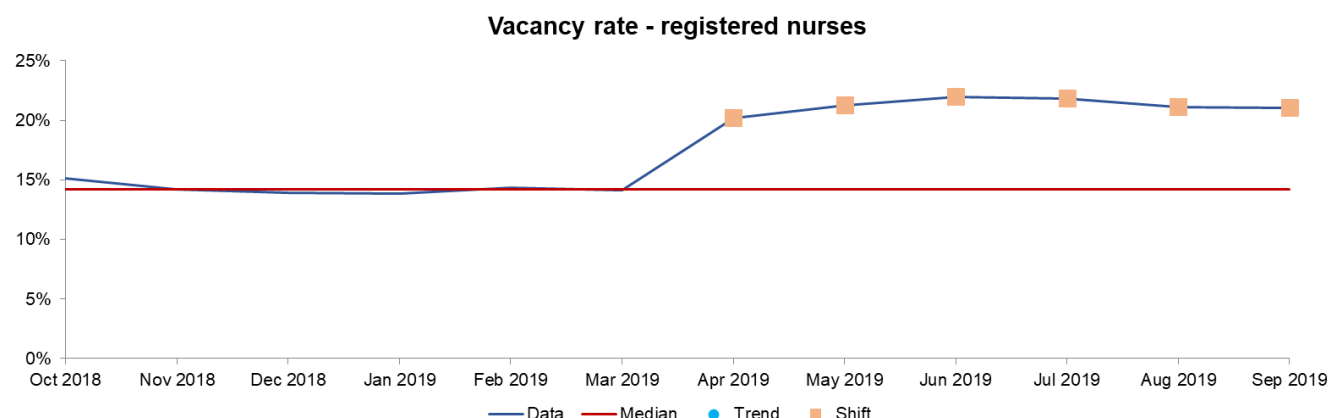
Surgery annual staffing metrics							
October 2018 to September 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	652	10%	18%	4.1%			
Qualified nurses	277	18%	10%	4.8%	54,118 (10%)	30,186 (6%)	11,423 (2%)

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

Nurse staffing rates within Surgery at Basingstoke and North Hampshire Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness and bank use.

Vacancy rates

The service had low and/or reducing vacancy rates.

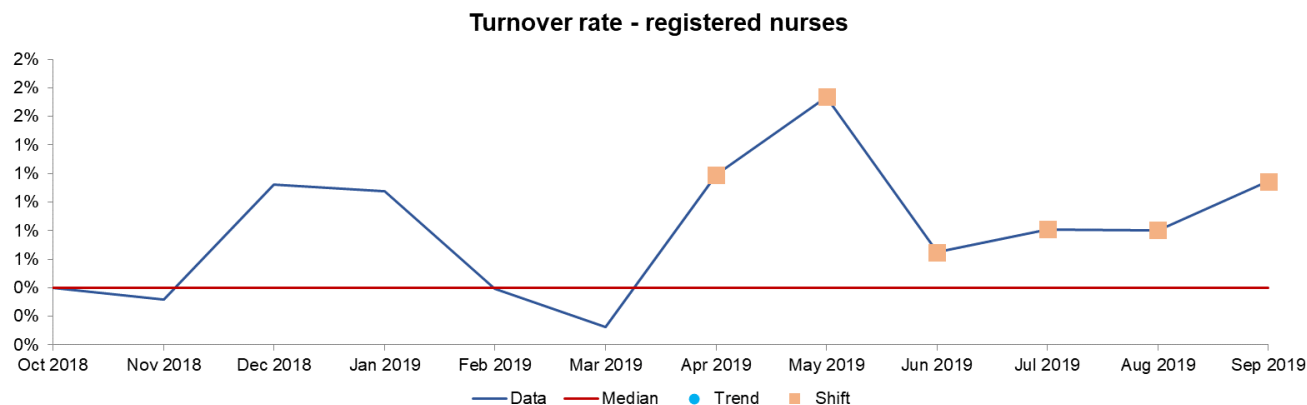


Monthly vacancy rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019. This could be an indicator of change.

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

Turnover rates

The service had low and/or reducing turnover rates. Managers told us the staffing turnover rates were monitored and the change to trauma / orthopaedic services had some impact on staffing. There was an ongoing recruitment plan in place, and this included some nurses who had recently been recruited from overseas.



Monthly turnover rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019.

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

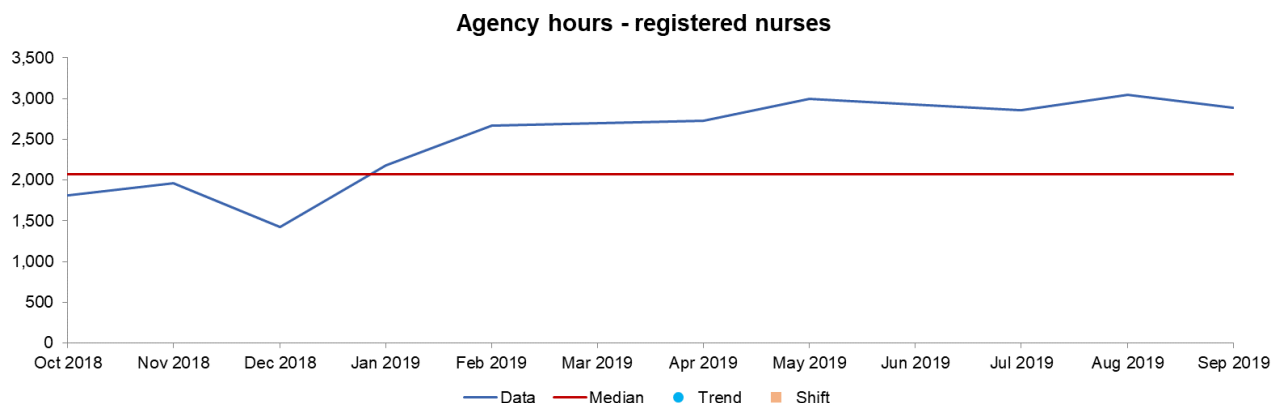
Sickness rates

The service had low and/or reducing sickness rates.

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

Agency staff usage

The service had low and/or reducing rates of bank and agency nurses.



Monthly agency use over the last 12 months for registered nurses were stable. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us they block booked agency nurses to ensure some degree of continuity in care. Agency nurses we spoke with told us they usually worked on the same wards or the surgical units.

Managers made sure all bank and agency staff had a full induction and understood the service.

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

Medical staffing

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

The service had enough medical staff to keep patients safe.

Trust level

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust's targets, where applicable. The Hampshire Hospitals NHS Foundation Trust has some medical staff that work across sites and therefore are not allocated to a specific site. These staff are captured under the trust level figures.

Surgery annual staffing metrics							
October 2018 to September 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual locum hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	1,241	9%	18%	3.7%			
Medical staff	318	10%	37%	0.9%	11,513 (2%)	1,521 (<1%)	0 (0%)

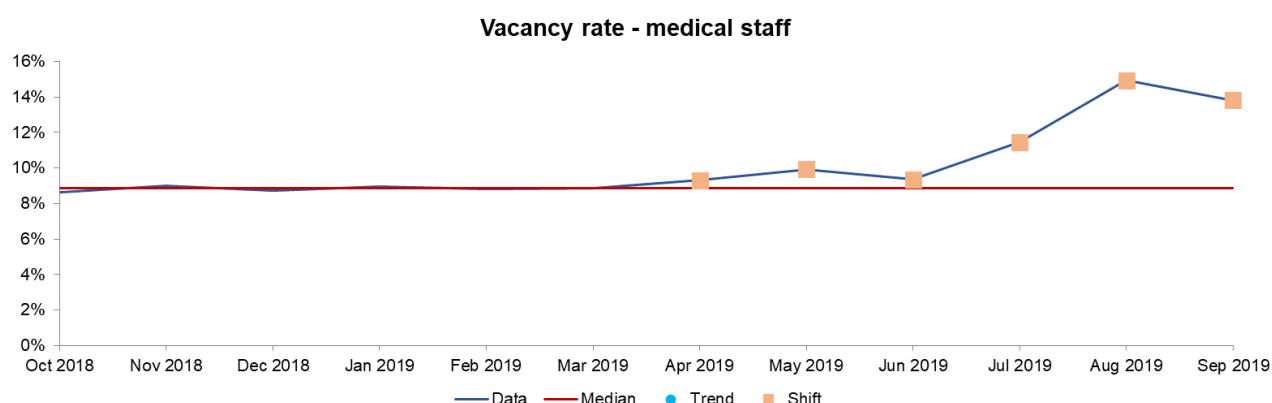
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The medical staff matched the planned number.

Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

Vacancy rates

The service had an increase vacancy rates for medical staff.



Monthly vacancy rates over the last 12 months for medical staff show an upward shift from April 2019 to September 2019. This could be an indicator of change.

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

Turnover rates

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

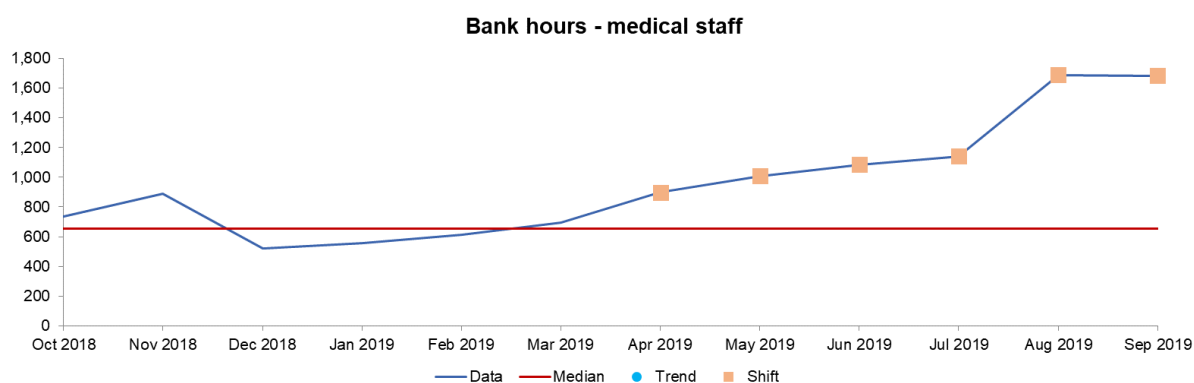
Sickness rates

The service had low and/or reducing sickness rates for medical staff.

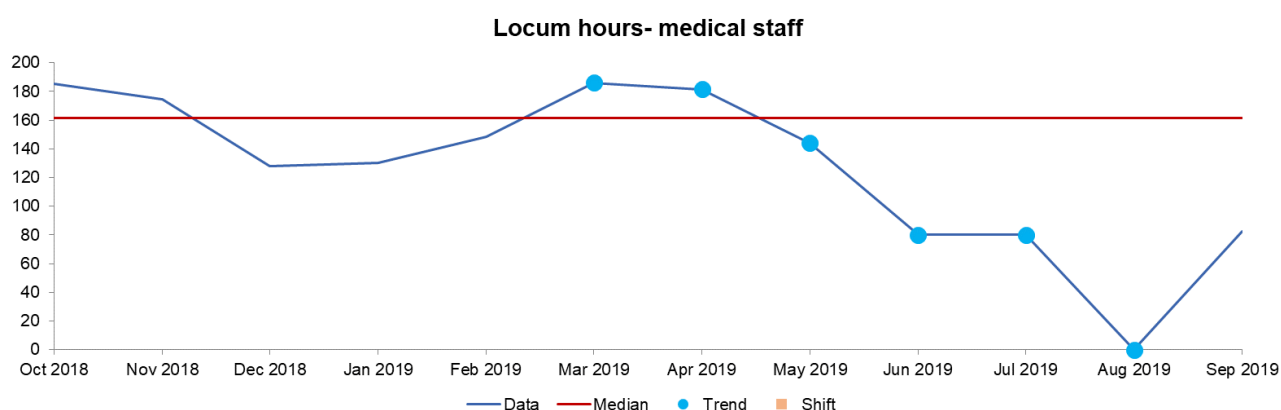
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The service had low and/or reducing rates of bank and locum staff.



Monthly bank use over the last 12 months for medical staff show an upward shift from April 2019 to September 2019. This could be an indicator of change.



Monthly locum uses over the last 12 months for medical staff show a downward trend from March 2019 to August 2019. This could be an indicator of change and actions taken by the trust to manage Locum usage.

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

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Basingstoke and North Hampshire Hospital

The service had enough medical staff to keep patients safe. The service had a good skill mix of medical staff on each shift and this was reviewed regularly. Records showed evidence of daily ward rounds, including review with senior clinicians. The Surgical wards had consultants covers including registrars, senior house officers and junior doctors on day shifts. At night, there was one registrar, one senior house officer and one junior doctor, with consultant on-call cover. C2 which was a pseudo myxomas ward had designated staff to manage the complex needs of these patients.

The table below shows a summary of the medical staffing metrics in surgery at Basingstoke and North Hampshire Hospital compared to the trust's targets, where applicable.

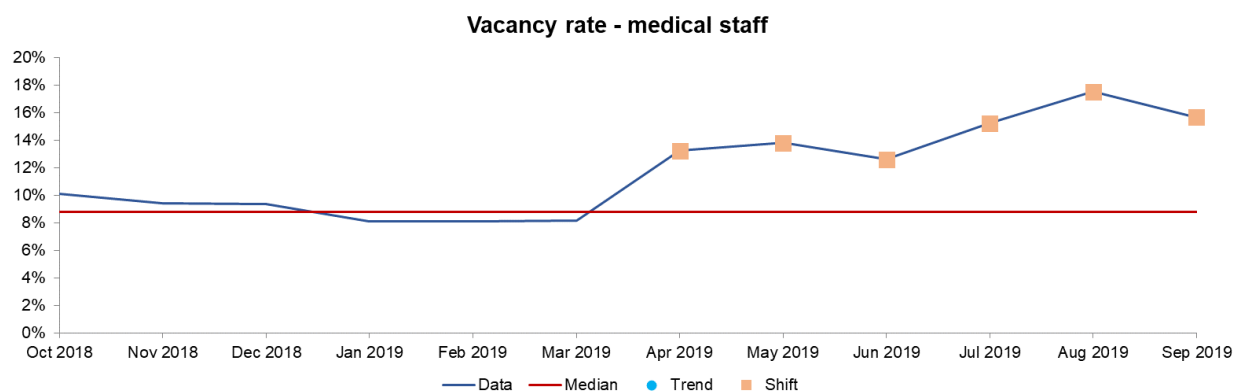
Surgery annual staffing metrics							
October 2018 to September 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual locum hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		8%	12%	3.5%			
All staff	652	10%	18%	4.1%			
Medical staff	154	12%	39%	1.3%	9,609 (3%)	0 (0%)	0 (0%)

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

Medical staffing rates within surgery at Basingstoke and North Hampshire Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and locum use.

Vacancy rates

The service had fluctuating vacancy rates for medical staff.



Monthly vacancy rates over the last 12 months for medical staff show an upward shift from April 2019 to September 2019. This could be an indicator of change.

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

Turnover rates

The service had low and/or reducing turnover rates for medical staff.

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

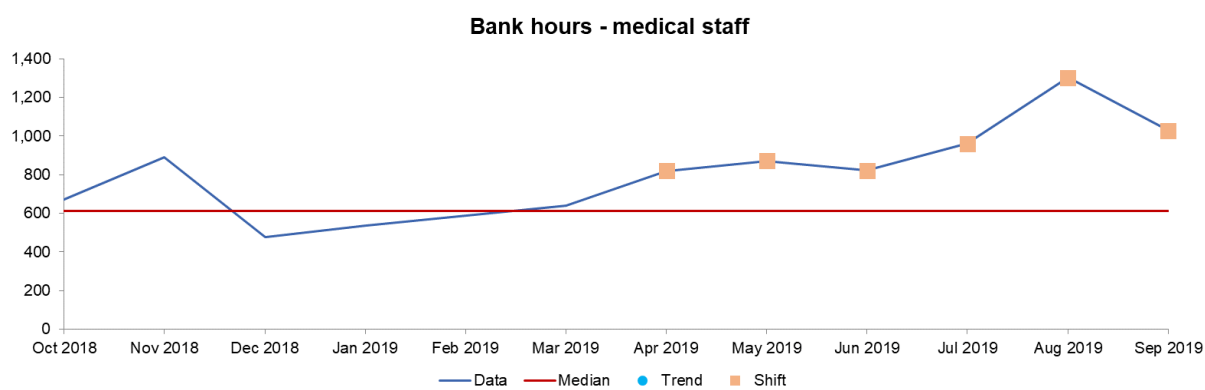
Sickness rates

The service had low and/or reducing sickness rates for medical staff.

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

Bank staff usage

The service had low and/or reducing rates of bank and locum staff.



Monthly bank use over the last 12 months for medical staff show an upward shift from April 2019 to September 2019.

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

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

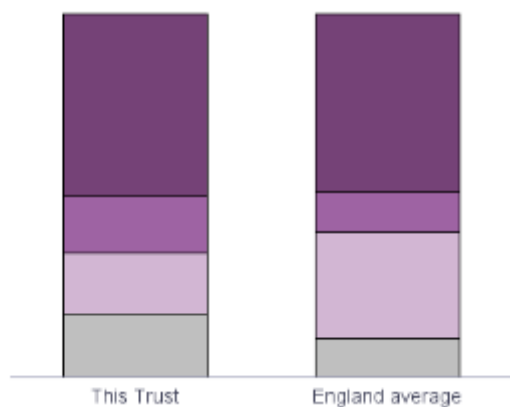
Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

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

Staffing skill mix for the whole-time equivalent staff working at Hampshire Hospitals NHS Foundation Trust

	This Trust	England average
Consultant	50%	49%
Middle career^	16%	11%
Registrar Group~	17%	29%
Junior*	17%	11%



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

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

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, mostly up-to-date, stored securely and available to all staff providing care.

The surgical unit used a combination of paper and electronic records. Although the majority of records were on the electronic patient records (EPR) which had been introduced trust wide, some records were recorded in paper formats. The patients' notes contained details of care and treatment and changes recorded, and staff said they could access them easily.

The care records contained pre-operative assessments, records of the surgical procedures, recovery observations, nursing notes and discharge checklists and assessments which were appropriate to the patient's clinical pathway.

All records were stored securely. We observed that access to the electronic patients' notes was password protected and staff ensured they logged off when the computers were not in use. We saw surgeon notes were detailed with evidence of daily reviews and clear post-operative management plans.

When patients transferred to a new team, there were no delays in staff accessing their records as these could be accessed on the electronic system. Patients who were transferred out of county had hard copies of their records sent with them.

However, there were different places for recording observations, including on the mobile electronic system and on charts such as care plans and charts kept at the patients' bedside. This may pose a risk as staff had to access different records in different places. In some cases, staff recorded the same information in more than one place- both electronically and on paper. This included VTE assessments which may cause confusion. Managers were aware of this and they were reviewing recording of VTE assessments for example on the e-recording system.

Patients records were not always consistently completed as we saw patients who had been assessed as at risk of malnutrition did not have a care plan. We brought this to the attention of the senior nurse on D4 during our inspection as the records for food and fluids were also not

effectively completed. We were assured that immediate actions would be taken including a review of the records. A senior staff told us this patient was known to the staff following a recent admission. The staff were monitoring their food and fluids intake and providing them with support and encouraging them to eat and the records would be reviewed to ensure they contained up to date information to meet the patients' needs.

Medicines

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

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. We observed that on C3 all medicines were stored safely and in alphabetical order which meant staff could access these easily. However, in one of the operating theatres, we found that medicines were drawn up and left in the anaesthetic room which was not in line with best practice and guidance. This posed risk of unauthorised personnel having access to medicines. This was raised with the provider during our feedback for actions to be taken.

We found the service did not manage FP10 prescriptions safely (these are prescriptions purchased by NHS organisation) and could be at risk of misappropriation. The FP10 pads were stored in a locked cabinet and staff maintained a log of FP10 which had been issued. In the day assessment unit, we found there were two lots of FP10 prescriptions in use by the surgery and pain team. Staff told us they were not aware of the standard operating procedure for the management of FP10. Staff were also unable to access the medicines policy at the time of the inspection.

There were no audits of FP10, and the trust could not be assured that this was managed safely. We reviewed the log and found this did not contain consecutive numbers of FP10 which had been used and the trust could not be assured that FP10 had not been stolen/ mislaid as there was no oversight.

Medical gases were not always stored securely as we found four oxygen cylinders were left loosely stored on the floor. A senior staff told us the cylinders should not be kept on the floor and actions would be taken to make these safe.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. On ward C2 there was a designated pharmacist as this was funded as part of the pseudo service.

The pharmacist and the pharmacy support team reviewed the wards stock regularly to ensure that stock levels of medicines remained adequate. Staff told us they could request additional medicines, and these were available at short notices which met the needs of patients.

Staff followed current national practice to check patients had the correct medicines. The pharmacy team carried out some drug reconciliation of patients' medicines on admission. Staff told us this usually occurred within 24 hours following admission. We noted that drug reconciliation had been completed in some of the records seen, this supported patients to continue receiving their medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Information about safety alerts were shared at handover and safety huddles. We found that controlled drugs (CDs) were stored securely in line with the Misuse

of Drugs (Safe Custody) Regulations (1973) and managed in line with the trust-controlled drug policy. A random review of the controlled drug register on the wards showed staff adhered to the medicines management policy and the register was fully completed which included two staff's signatures for the administration of CDs. The CD registers were maintained securely. There was one incident on C3 during the reporting period where the CD register for patients own CD was accidentally destroyed. This was raised as an incident, investigated and action was developed to minimise risk of this re-occurring.

In theatres we saw that CDs were checked at the beginning and end of the theatre lists and signed by nurses and operating department assistant (ODA) as appropriate. In the trauma theatre, CD checks were completed at handover. We reviewed the theatre CD audits and found the service was compliant and staff adhered to the trust procedures for the management of CDs.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff said they had a multi-disciplinary approach for prescribing medicines, and this was reviewed during the daily ward rounds.

Medicines were kept in designated fridges and staff monitored the minimum and maximum temperature to ensure these were maintained in line with the manufacturer's recommendation. Medicines were disposed of safely and we saw separate documentations were maintained when they were returned to pharmacy.

The storage of intravenous fluids (IV) was not in line with best practice as IV fluids which contained higher concentration of potassium were not kept separately and may pose a safety risk as these were not segregated. Our pharmacy inspector had raised this with staff as this was in other services we looked at.

Incidents

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

Staff knew what incidents to report and how to report them using their internal on-line reporting system. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff discussed incidents at handovers and morning meetings. We also saw incidents had been recorded in ward meetings. For example, there were monthly meetings, which had a standard agenda, to discuss serious incidents, which had resulted in harm to patients.

Following a serious incident where a patient was attached to medical air instead of oxygen. The trust took necessary action which included the removal of all air flow meters from some areas. Also, they used caps to go over walled air outlets, so that they were clearly labelled as such to minimise the risks of this re occurring.

Never events

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

From December 2018 to November 2019, the trust reported two never events for surgery.

The first incident, a surgical/invasive procedure incident meeting SI criterion, took place at Basingstoke and North Hampshire Hospital in December 2018. The incident involved a patient undergoing a revision knee replacement (conversion of unilateral knee replacement to total knee replacement). Following surgery, it was identified that the wrong implant was used.

The service followed their procedure and following a root cause analysis, an action plan was developed to minimise the risk of this sort of incident occurring.

The second incident, a surgical/invasive procedure incident meeting SI criterion, took place at Royal Hampshire County Hospital in June 2019. The incident involved the extraction of the wrong tooth during a planned outpatient appointment.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2018 to November 2019. A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	11	55%
Pressure ulcer meeting SI criteria	3	15%
Surgical/invasive procedure incident meeting SI criteria	2	10%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	5%
Medication incident meeting SI criteria	1	5%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	5%
VTE meeting SI criteria	1	5%
Total	20	100%

(Source: Strategic Executive Information System (STEIS))

Basingstoke North Hampshire Hospital

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in surgery at Basingstoke and North Hampshire Hospital which met the reporting criteria set by NHS England from December 2018 to November 2019. A breakdown of the incident types reported is in the table below:

(Source: Strategic Executive Information System (STEIS))

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	8	57%
Pressure ulcer meeting SI criteria	2	14%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	7%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	7%
Surgical/invasive procedure incident meeting SI criteria	1	7%
VTE meeting SI criteria	1	7%
Total	14	100%

Senior staff we spoke to were aware of their responsibilities relating to Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of “certain notifiable safety incidents” and provide them with reasonable support.

Managers shared learning about never events with staff. We reviewed the root cause analysis investigation for one of the never events within the reporting period. We saw evidence of a thorough investigation and patient involvement. The investigation identified the root causes of the incident and made recommendations for learning. We saw staff had implemented learning following both never events during our visit to theatres

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Managers debriefed and supported staff after any serious incident.

Safety thermometer

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

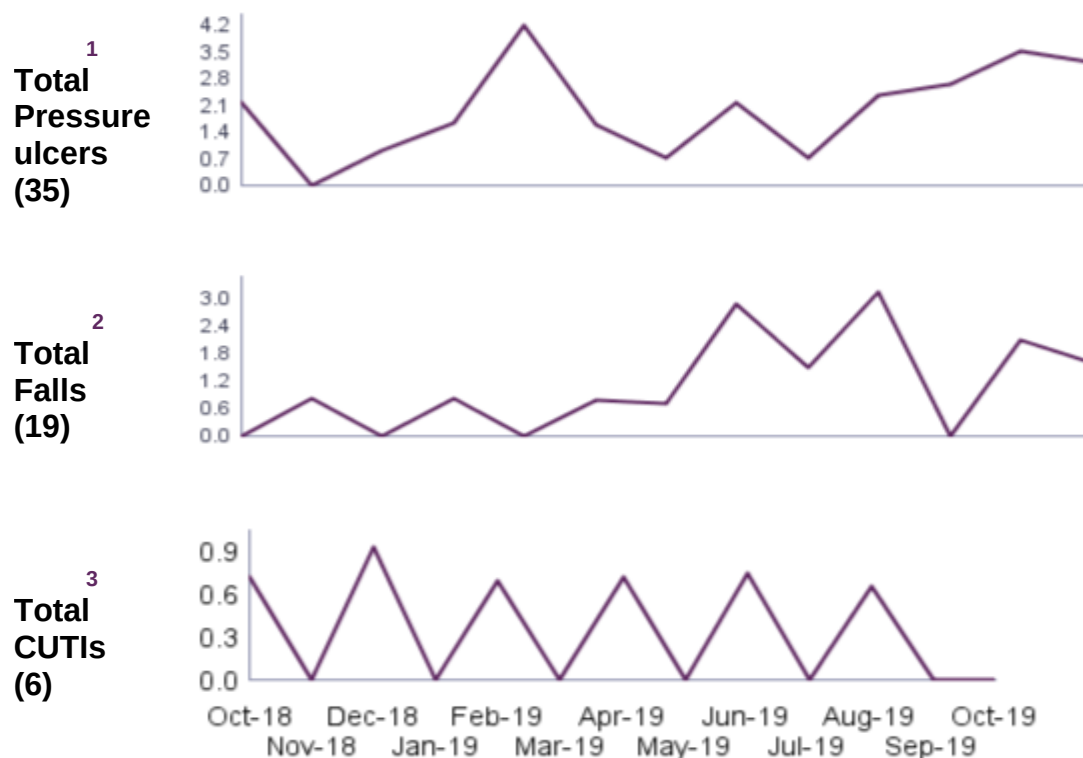
Safety thermometer data was not displayed on wards for staff and patients to see. The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

The service collected safety thermometer data for incidences of patients fall, pressure ulcers, infections, catheter related urine infection and venous thromboembolism (VTE). The safety thermometer showed the service had reduced the incidence of harm within the reporting period. Staff used the safety thermometer data to further improve services. Safety thermometer data was discussed at team meetings and matron told us plans were developed as appropriate.

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

Data from the Patient Safety Thermometer showed that the trust reported 35 new pressure ulcers, 19 falls with harm and six new urinary tract infections in patients with a catheter from October 2018 to October 2019.

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



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

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

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. This included the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons (RCS). Elective patients had routine pre-operative tests in line with NICE guideline NG45

Staff monitored patients' temperatures in theatres in line with NICE Clinical Guideline CG65- Hypothermia: prevention and management in adults having surgery.

Staff monitored patients following surgery in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration. We reviewed patients' records, which

showed evidence of regular observations such as blood pressure, heart rate and oxygen saturation, in line with the guidance.

Staff followed guidance for surgical site infection- prevention and treatment in line with Patients NICE guideline (NG125) which included antiseptic skin preparations and antibiotics before skin closures.

Patients were assessed using the American Society of Anaesthesiologists (ASA) grading system for pre-operative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The system enabled the staff and anaesthetists to plan specific post-operative care for patients as required.

The service audited staff compliance with trust policies and national guidance. This included monthly audits on the World Health Organisation (WHO) Surgical Safety Checklist. Audits provided assurances around adherence to the safety checklist and helped identify areas for improvement.

Staff protected the rights of patient's subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition, patients were assessed, and records were maintained. Care plans were developed and information about patients' nutritional needs were shared among the team we observed staff provided support to patients at meal times. Relatives were encouraged to provide assistance with meals if they wished to do so.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. In C2 staff told us they had received training in supporting patients requiring parenteral nutrition. This is a method of supplementing feeding through a tube placed into the stomach or small bowel for patients who cannot eat or absorb enough food to maintain adequate dietary intake. Patients received specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it.

Patients were supported to complete their menus daily and were provided with food choices to meet their needs. This considered patients' diverse dietary and cultural needs such as vegetarian religious and diabetics.

Patients who had major elective surgery were given information about fasting as part of their pre-op preparations. National and European Anaesthesia Societies recommended intake of clear fluids up to two hours before the induction of anaesthetic as well as six hours fast for solid food prior to surgery. This staff told us were mainly adhered to by most surgeons.

However; in the day admission ward, staff told us this was not followed as patients were told to fast for up to twelve hours prior to surgery. Staff told us the guidance was not followed as some consultants recommended their preferred fasting times. We spoke with two patients who told us they had not eaten or drank since 8 pm the previous evening as they had been advised. Extended

starving periods may cause undue discomfort to patients prior to surgery as this was not in line with good practice guidelines.

The records of food and fluids were not consistently completed. We reviewed the records of three patients who had been identified as at risk of malnutrition. There were gaps in the records that meant staff could not identify what the patient had eaten or drunk in a 12-hour period. We spoke to the nurse in charge who confirmed that the patients were on food charts and this had not been completed and immediate actions would be taken.

Pain relief

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

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients on the wards said they received pain relief in a timely manner. Patients told us nurses regularly asked them about any pain they might have and gave pain relief promptly if necessary. A patient told us 'I was worried about pain, but 'the nurses kept on top of it'

Another patient told us they had received information about pain management when they had their pre-assessment prior to their surgery. Staff carried out regular assessment of patients' pain and this formed part of NEWS scores.

Patients had access to a variety of pain relief as appropriate to their surgery. This included epidural and patient-controlled analgesia (PCA). Staff told us they assessed patients who required this type of pain relief before their operation and gave them information to ensure that they understood how the delivery of the medication worked. Staff completed regular assessments when PCA was used to ensure that patients' pain was controlled, the equipment worked appropriately and monitored any unwanted side effects.

Patients' records showed staff took appropriate actions when patients pain was not well controlled for example the anaesthetist was contacted for a patient who had an epidural, they had responded, and the epidural was topped up.

Patients records contained the recognised pain assessment tool used for patients who may not be able to verbalise their pain. Medicines records showed patients received regular pain control as prescribed and recorded pain relief accurately.

Patient outcomes

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

The service participated in relevant national clinical audits. Patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement, inguinal hernia repair and varicose veins.

This report looks at the quality of care provided to people with dementia in general hospitals, specifically aspects of care delivery known to impact upon people with dementia as inpatients.

The trust took part in the National dementia audit and the result was published in December 2019. The trust scored above the national average for most of the audit they took part in. The trust

scored 74% which was above national average for initial assessment of delirium (change in the brain that causes mental confusion and emotional distress that may occur following surgery and dementia) compared to national score of 55%. They also scored 100% for personal information about the person living with dementia being obtained compared to the national average of 59%.

Managers and staff used audit results to improve patient outcomes. The trust had developed an action plan which included improving assessment for delirium using a standardised tool, and a reduction in bed moves for patients with dementia and delirium. The relationship between delirium and dementia would be included in Level 2 dementia training.

Trust level

From June 2018 to May 2019, patients at the trust had a similar to expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a similar to expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions – Trust Level



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

Patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Colorectal surgery patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

England Avg. —



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

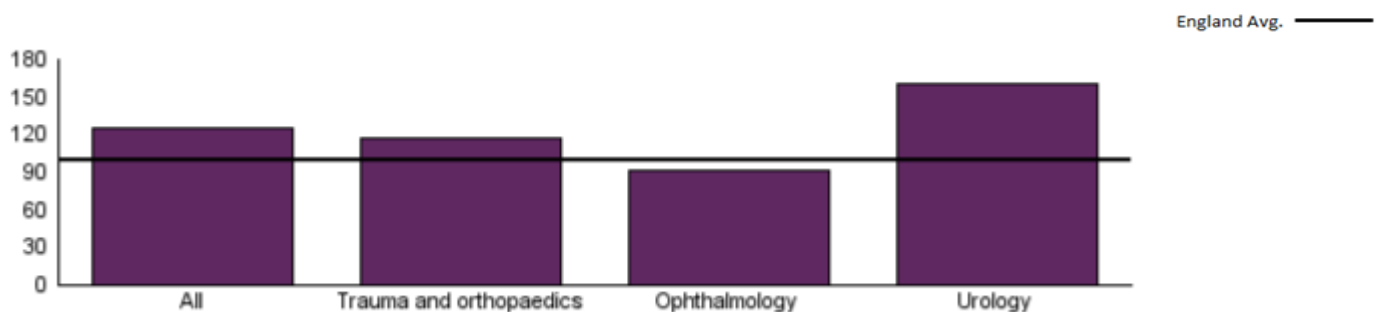
(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2018 - 31/05/2019))

Basingstoke and North Hampshire Hospital

From June 2018 to May 2019, patients at Basingstoke and North Hampshire Hospital had a higher than expected risk of readmission for elective care when compared to the England average.

- Trauma and orthopaedics patients at Basingstoke and North Hampshire Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Ophthalmology patients at Basingstoke and North Hampshire Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Basingstoke and North Hampshire Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Basingstoke and North Hampshire Hospital



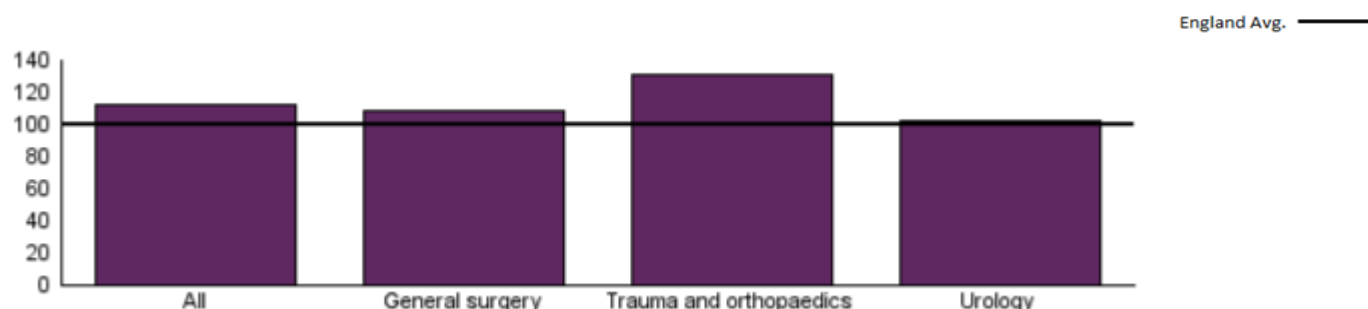
Note: Ratio of observed to expected elective admissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed admissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

Patients at Basingstoke and North Hampshire Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at Basingstoke and North Hampshire Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Basingstoke and North Hampshire Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at Basingstoke and North Hampshire Hospital had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - Basingstoke and North Hampshire Hospital



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

National Hip Fracture Database

Basingstoke and North Hampshire Hospital

The table below summarises Basingstoke and North Hampshire Hospital's performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

Metrics (Audit indicators)	Hospital performance	Comparison to other Trusts	Met national standard?
Case ascertainment (Proportion of eligible cases included in the audit)	100.9%	Better	Met
Crude proportion of patients having surgery on the day or day after admission (It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)	78.1%	Similar	Did not meet
Crude peri-operative medical assessment rate (NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)	86.8%	Worse	Did not meet
Crude proportion of patients documented as not developing a pressure ulcer (Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's admission); this measures an organisation's ability to report 'documented as no pressure ulcer' for a patient	92.7%	Worse	Did not meet

Crude overall hospital length of stay (A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)	18.7 days	Similar	No current standard
Risk-adjusted 30-day mortality rate (Adjusted scores take into account the differences in the case-mix of patients treated)	11.5%	Negative Outlier	No current standard

The trust crude proportions of patients documented as not developing pressure ulcers was 92% and worse when compared with other trusts.

The trust also undertook a pressure ulcer care audit in December 2019 which scored 80%. An action plan was developed which included nurse in charge to communicate with ward team regarding the importance of pressure risk assessment completion and care plans. Staff had been reminded to complete pressure ulcer care training and to seek support from the tissue viability nurses to achieve compliance by 31 January 2020.

Bowel Cancer Audit

Basingstoke and North Hampshire Hospital

The table below summarises Basingstoke and North Hampshire Hospital's performance in the 2018 National Bowel Cancer Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Met national standard?
Case ascertainment (Proportion of eligible cases included in the audit)	68.0%	Fair	Fair is between 50%- 80%
Risk-adjusted post-operative length of stay >5 days after major resection (A prolonged length of stay can pose risks to patients)	75.4%	Worse than national aggregate	No current standard
Risk-adjusted 90-day post-operative mortality rate (Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)	1.3%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate (Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)	Not reported	N/A	No current standard
Risk-adjusted 30-day unplanned readmission rate (A potential risk for early/inappropriate discharge)	2.3%	Better than expected	No current standard

<i>is the need for unplanned readmission)</i>			
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection <i>(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases, it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)</i>	30.5%	Positive outlier	No current standard

The trust performed better than expected for the 30-day unplanned readmission and was a positive outlier for the 18-month temporary stoma rate for rectal cancer when compared with similar trusts.

National Vascular Registry

The trust did not take part in this audit.

(Source: National Vascular Registry)

National Oesophagus-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises Hampshire Hospitals NHS Foundation Trust's performance in the 2018 National Oesophagus-gastric Cancer Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Met national standard?
Trust-level metrics <i>(Measures of hospital performance in the treatment of oesophagus-gastric (food pipe and stomach) cancer)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	71 to 80%	Similar	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission <i>(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</i>	0.8%	Better	No current standard
Risk adjusted 90-day post-operative mortality rate <i>(Proportion of patients who die within 90 days of their operation)</i>	Not eligible	N/A	No current standard
Cancer Alliance level metrics <i>(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophagus-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)</i>			

Crude proportion of patients treated with curative intent in the Cancer Alliance (Proportion of patients receiving treatment intended to cure their cancer)	42.6%	Better	No current standard

(Source: National Oesophagus-Gastric Cancer Audit)

National Emergency Laparotomy Audit

Basingstoke and North Hampshire Hospital

The table below summarises Basingstoke and North Hampshire Hospital's performance in the December 2016 to November 2017 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 55% of patients achieving the standard), amber (between 55% and 85% of patients achieving the standard) and green (more than 85% of patients achieved the standard).

Metrics (Audit measures)	Hospital performance	Audit's Rating	Met national standard?
Case ascertainment (Proportion of eligible cases included in the audit)	59%	Amber	Did not meet
Crude proportion of cases with pre-operative documentation of risk of death (Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)	78%	Amber	Did not meet
Crude proportion of cases with access to theatres within clinically appropriate time frames (Proportion of patients who were operated on within recommended times)	86%	Green	Met
Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre (Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)	97%	Green	Met
Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to surgery post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)	100%	Green	Met
Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)	9%	Within expected range	No current standard

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises Hampshire hospitals NHS Foundation Trust's performance in the 2018 National Ophthalmology Database Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Met national standard?
Trust-level metrics (Measures of hospital performance in the treatment of cataracts)			
Case ascertainment (Proportion of eligible cases included in the audit)	74.8%	N/A	No current standard
Risk-adjusted posterior capsule rupture rate (Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.)	0.6%	Positive outlier	No current standard
Risk adjusted visual acuity loss (The most important outcome following cataract surgery is the clarity of vision)	0.3%	Positive outlier	No current standard

(Source: National Ophthalmology Database Audit)

The trust was a positive outlier for two of the three outcomes measures for posterior capsule rate and risk adjusted visual acuity loss in the National ophthalmology database audit.

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

Basingstoke and North Hampshire Hospital

The table below summarises Basingstoke and North Hampshire Hospital's performance in the 2018 National Joint Registry.

	Metrics (Audit measures)	Hospital performance	Comparison to other hospitals	Met national standard?
Trust-level	Case ascertainment (hips, knees, ankles and elbows) (Proportion of eligible cases within the trust that were submitted to the audit)	81.9%	Similar	Did not meet
	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) (Patient details help 'track and trace' prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)	95.3%	Better	Did not meet
Hospital level: Hips	Risk-adjusted 5-year revision ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who need their hip replacement 're-doing')	1.4	Worse than expected	Did not meet

	Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who die within 90 days of their operation)	1.0	Within expected range	Met
Hospital level: Knees	Risk-adjusted 5-year revision ratio (for knees excluding tumours) (Proportion of patients who need their knee replacement 're-doing')	1.2	Within expected range	Did not meet
	Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) (Proportion of patients who die within 90 days of their operation)	1.0	Within expected range	Met

National Prostate Cancer Audit

The table below summarises Hampshire Hospitals NHS Foundation Trust's performance in the 2018 National Prostate Cancer Audit.

Metrics (Audit measures)	Hospital performance	Comparison to other trusts	Met national standard?
Men with complete information to determine disease status (This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)	89.8%	N/A	Did not meet
Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy (A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)	No data available	N/A	No current standard
Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy (Complications following surgery may reflect the quality of surgical care)	No data available	N/A	No current standard
Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy (External beam radiotherapy uses high-energy beams to destroy cancer cells)	22.1%	Within expected range	No current standard

(Source: National Prostate Cancer Audit)

Adult cardiac surgery

The trust did not take part in this audit.

(Source: National Cardiac Audit Programme)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes were measured in a number of different ways, descriptions of some of the indicators presented are below.

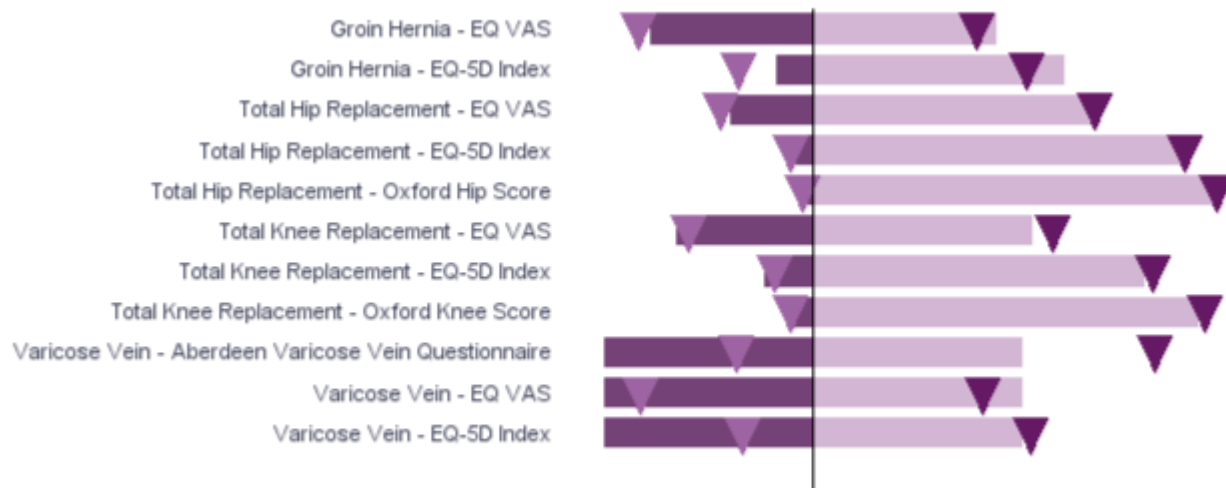
Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.

■ % Trust improved ■ % Trust worsened ▼ % England improved ▼ % England worsened



In 2016/17 performance on groin hernias was better than the England average for both EQ VAS and EQ-5D Index indicators.

In 2016/17, performance on varicose veins, was worse than the England average for the Aberdeen varicose vein questionnaire, EQ VAS and EQ-5D index indicators.

For hip replacements, performance was about the same as the England average for EQ VAS, EQ-5D index and the Oxford hip score indicators.

For Knee replacements performance was better than the England average for the Oxford knee score, EQ VAS and EQ-5D index indicators.

(Source: NHS Digital)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers and staff investigated audit outliers, implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits. Improvement is checked and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. All new staff completed a trust induction programme when they joined the service in line with the trust's policy. Mandatory training included modules such as moving and handling, safeguarding, infection control, mental capacity act, and basic life support.

Newly qualified nurses had access to the preceptorship programme which included an induction programme, practice-based competencies and a number of additional training days. Some new nurses we spoke with during the inspection told us they worked supernumerary and were supported by other staff and they had a planned induction programme.

The clinical educators supported the learning and development needs of staff. Managers made sure staff attended team meetings or had access to meeting minutes when they could not attend.

Staff who worked on C3, the peritoneal malignancy ward followed a 20-week ward nursing competency/ induction to equip them with the skills and knowledge to care for these types of patients. The programme included a minimum of two weeks where the nurses were supernumerary to allow them to spend time with specialist nurses on the wards and in clinics. Managers identified poor staff performance promptly and supported staff to improve and a senior manager told us of actions the trust had taken to manage performance issues in one of the wards.

Specialist nurses and teams were in place to support wards and departments and assisted with planning care and treatment for patients with specific conditions. These included stoma and pain specialist nurses. Staff told us they found these specialists helpful and they were easy to get hold of. During our inspection we saw specialist staff such as dietitians, physiotherapists and stoma care nurses assisting nurses and supporting care of patients.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

Trust level

As at September 2019, 89.0% of required staff in surgery received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Estates and ancillary	16	17	94.1%	90%	Yes
Allied health professionals	24	26	92.3%	90%	Yes
Additional clinical services	211	229	92.1%	90%	Yes
Administrative and clerical	188	209	90.0%	90%	No
Nursing and midwifery registered	372	421	88.4%	90%	No
Medical and dental	157	181	86.7%	90%	No
Add prof scientific and technical	28	36	77.8%	90%	No
Total	996	1,119	89.0%	90%	No

Basingstoke and North Hampshire Hospital

As at September 2019, 90.8% of required staff in surgery Basingstoke and North Hampshire Hospital received an appraisal compared to the trust target of 90%. The breakdown by staff group can be seen in the table below:

Staff group	September 2019

	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional clinical services	133	138	96.4%	90%	Yes
Allied health professionals	12	13	92.3%	90%	Yes
Nursing and midwifery registered	207	228	90.8%	90%	Yes
Add prof scientific and technical	8	9	88.9%	90%	No
Administrative and clerical	93	106	87.7%	90%	No
Medical and dental	81	94	86.2%	90%	No
Estates and ancillary	6	7	85.7%	90%	No
Total	540	595	90.8%	90%	Yes

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nurses told us they found the process useful. Data provided by the trust showed the nursing and allied health professionals had met and some exceeded the 90% trust target.

The trust had developed the clinical educators' roles which supported the learning and development needs of staff. Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Managers identified poor staff performance promptly and supported staff to improve. A senior manager gave us example of actions the trust had taken to effectively manage this and including behaviours. Managers recruited, trained and supported volunteers to support patients in the service.

Multidisciplinary working

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

During the inspection we observed good and effective multidisciplinary team (MDT) working throughout surgical services. MDT working was an embedded practice which supported the delivery of joined up care. Staff from different disciplines such as physiotherapy, occupational therapists, pharmacy and specialist nurses including a stoma nurse told us that communication was good and provided positive outcomes for patients.

All care pathways were multi-disciplinary, and staff of all disciplines developed and supported each other in the planning and delivering of patient care. Each professional group recorded their assessments in the electronic patient records which meant it was easy to access information about the outcome of the evaluation and the ongoing care of the patients. We observed patient care on surgical wards was supported by a variety of teams. This included pharmacists, occupational therapists and physiotherapists, all working together to deliver individual care to patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care

for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Staff worked with the multidisciplinary team when planning patients' discharge home or in the community such as community teams and care homes. Records contained information from physiotherapists and occupational therapists on patients' suitability and plan for discharge.

Staff provided a verbal feedback when patients were transferred to the discharge lounge and sent a discharge summary which contained information about medicines, pain control and other information such as if the patients was diabetic and transport arrangements.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There were a number of medical outliers in the surgical wards and the trust had arrangement in place, whereby the medical team reviewed these patients daily on weekdays. At the weekends the medical on call team provided support and reviews of patients as requested.

The operating theatres provided emergency service 24 hours a day which included trauma orthopaedic, gynaecology, urology. gastro enterology for bleeds. This ensured patients received care and treatment in a timely manner to meet their needs. Staff in theatre had an on-call system and were available out of hours and weekends. The pharmacy team was available Monday to Saturday and there was an on-call system to support the staff at other times. Allied health professionals including physiotherapy and radiology provided care and support seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

These included weight losses, smoking and alcohol cessation services. We also saw leaflets providing practical advice for patients and carers on falls and pressure ulcer prevention. The wards had display boards educating patients on improving their health, such as the importance of drinking enough water.

Staff told us they identified patients who smoked at the pre- assessment meeting prior to their elective surgery and provided information about risks of chest infection and advice on reducing the number of cigarettes they smoked immediately before their operation.

An allied health professional also said they discussed weight loss pre and post-surgery for orthopaedic patients and impact excess weight may have on their mobility.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records, and this was evidenced in the records seen. For example, patients on C2 saw the consultants and their surgery was discussed. Patients were allowed a cooling off period. Patients were admitted two days prior to their surgery and consents were completed.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing and other clinical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust had set a 90% target for MCA and DoLS training, this was not achieved as this was 73%. Managers told us staff were sent reminders when they showed as amber on their training record system. The service was looking at ways to support the staff to achieve their overall training targets.

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	333	459	73%	90%	No

In surgery the target was not met for MCA/DoLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training modules from April to September 2019 at trust level for medical staff in surgery is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	173	290	59.7%	90%	No

In surgery the 90% target was not met for MCA/DoLS training modules for which medical staff were eligible as this was 59%.

Basingstoke and North Hampshire Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training modules from April to September 2019 for qualified nursing staff in surgery at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	191	275	69.5%	90%	No

In surgery the target was not met for MCA/DoLS training modules for which qualified nursing staff at Basingstoke and North Hampshire Hospital were eligible.

A breakdown of compliance for MCA/DoLS training modules from April to September 2019 for medical staff in surgery at Basingstoke and North Hampshire Hospital is shown below:

Training module name	April to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental capacity act level 1	97	167	58.1%	90%	No

In surgery the target was not met MCA/DoLS training modules for which medical staff at Basingstoke and North Hampshire Hospital were eligible.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice). Staff could give us examples of referrals they had made and included discussions with their managers in order to protect people in their care.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff told us of their deprivation of liberty process which included referrals to the local authority as appropriate.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. We saw numerous instances of staff supporting patients in a compassionate way including those with dementia.

Staff introduced themselves and other healthcare professionals who were involved in their care. We observed staff supporting patients with their personal care ensuring their privacy and dignity was maintained. Staff in the operating theatres introduced themselves and the team members in a caring way and reassured them.

Patients spoke positively about the way staff treated them and the attention and support they received from staff which was above their expectations. A patient told us the staff were there to offer support and compassion to them which they said was at a difficult time for them. Patients told us staff treated them with compassion and understood their anxiety relating to the planned major surgery and pain management.

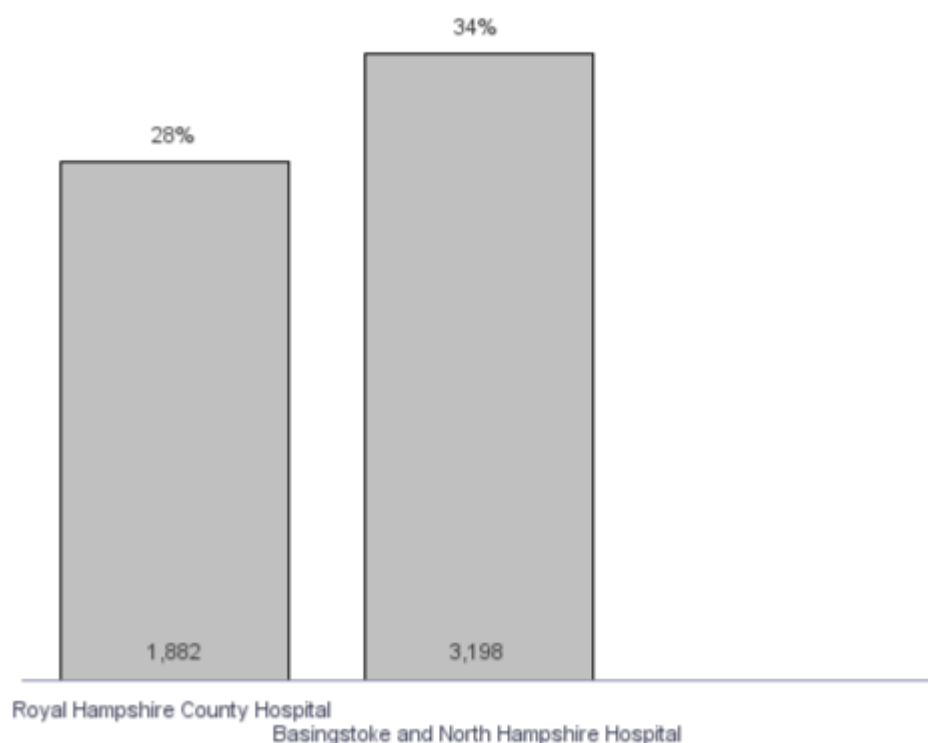
Friends and Family test performance

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

The Friends and Family Test response rate for surgery at Hampshire Hospitals NHS Foundation Trust was 28% which was better than the England average of 24% from October 2018 to September 2019.

A breakdown of response rate by site can be viewed below.

Friends and family test response rate at Hampshire Hospitals NHS Foundation Trust, by site



Ward name	Total Resp ^{1,2}	Resp. Rate	Percentage recommended ³												Annual perf ¹
			Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Oct-19	
DTCW IP	772	52%	98%	96%	98%	100%	99%	100%	98%	96%	98%	98%	100%	98%	98%
TC ENDO & SUR IP	699	27%	96%	100%	98%	93%	93%	99%	94%	96%	100%	98%	97%	96%	96%
C3 IP	667	24%	94%	97%	98%	95%	100%	97%	100%	96%	93%	98%	94%	97%	96%
D1 IP	528	34%	95%	94%	98%	94%	100%	100%	95%	98%	100%	99%	100%	100%	98%
C4 IP	486	37%	100%	97%	96%	98%	98%	100%	100%	98%	100%	96%	96%	96%	98%
D3 IP	288	29%	100%	94%	92%	85%	88%	100%	97%	94%	96%	100%	92%	91%	93%
SHAWFORD IP	280	28%	100%	100%	95%	96%	95%	100%	100%	94%	95%	94%	96%	97%	97%
KEMP WELCH IP	273	21%	100%	98%	100%	100%	100%	97%	95%	86%	100%	96%	100%	92%	97%
WYKEHAM IP	266	64%	91%	100%	100%	96%	100%	95%	100%	100%	93%	88%	89%	96%	96%
D4 IP	238	31%	92%	100%	100%	92%	95%	100%	100%	100%	95%	95%	97%	93%	97%
C2 IP	219	41%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%
TWYFORD IP	194	28%	100%	100%	100%	100%		100%	100%	89%	100%	100%	100%	88%	97%
BARTLETT IP	167	27%	100%	90%	92%	100%	100%	100%	95%	100%	100%	100%	100%	100%	97%

Highest score to lowest score
Key 100% 50% 0%

- The total responses exclude all responses in months where there were less than five responses at a ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.
- Sorted by total response.
- The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with were positive about the emotional support they received. A patient in C2 told us how the staff including the dietitian had spent time discussing their post-operative food and fluids management with them.

Another patient told us they were anxious about the outcome of their surgery. They told us the staff took time to support them, listening to them and providing reassurance which they said, "made all the difference".

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff supporting a patient with dementia and using diverting tactics to keep the patient calm. On another ward staff suggested they go off for a walk which appeared to calm a patient who was agitated.

Patients were offered, and had access to, further support and counselling. Patients admitted to C2 had dedicated psychologist assigned to the ward and assessed patients on admission and were also screened for delirium. The staff were informed of any 'flagged' patients, so they could be monitored and received appropriate support.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The hospital's chaplaincy team provided spiritual and emotional support for patients and relatives of all faiths. The chaplains were available 24 hours a day, seven days a week and staff told us they would also help patients to access support from other religions.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care. For example, patients undergoing major abdominal surgery were provided with detailed information prior to surgery. They were seen by the multi- disciplinary team to ensure they were supported in making decisions about their care and treatment and the outcome of their surgery.

Staff gave us an example where they had liaised with the parent of a patient with a learning difficulty. Arrangements were made for the patient to be admitted directly to a ward instead of the admission ward where they were likely to wait for a bed to be allocated. The staff had gone the extra mile to ensure this patient experienced minimal distress and care and support effectively met their complex needs.

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The trust had reconfigured their trauma and orthopaedic services following consultation with the public, the local commissioning groups and staff. This included East Berkshire and Berkshire West who commissioned care. They also and presented a paper to the health and social care select committee in 2019. As part of the plan, the service would be able to provide orthopaedic trauma services seven days a week. Also, to create an elective centre of excellence for large operations such as hip and knee replacements.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service monitored such breaches, and this showed the incidents were low.

Facilities and premises were appropriate for the services being delivered. Patients with limited mobility and wheelchair users had safe access to the areas they were receiving care. Equipment was available and included chairs, wheelchairs, beds and operating theatre tables included those for bariatric patients.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. This was in line with assessment of mental health services in acute setting (AMSAT).

The service had systems to help care for patients in need of additional support or specialist intervention. This included the service for pseudomyxoma patients (a rare form of abdominal cancer) which accommodated patients from across the country as the service was one of two centres that offered this type of surgery.

Managers monitored and acted to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted and offered another appointment.

The service relieved pressure on other departments when they could treat patients in a day. The surgical services had developed their day admission service to meet the needs of patients and improve access and flow. Patients were admitted to the admission ward prior to their procedure and then transferred to a ward.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We spoke with a staff member who had referred a patient requiring mental health support to an external local provider for an assessment of their needs. The service linked with the local commissioning team, GPs and community teams to provide effective patients' care.

Wards were designed to meet the needs of patients living with dementia which included appropriate colour schemes and signages to support these patients. Staff were also allocated to the bays to ensure patients who required observations and support received this safely.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Although the passport for patients with dementia were not consistently completed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. This included hearing loops and information in different formats including large prints. The service had arrangements in place with an external service and could provide information leaflets in languages spoken by the patients and local community.

Managers made sure staff, patients' family and carers could get help from interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service reviewed waiting times, and these were rated as red amber and green. The service was taking action to reduce the waiting times in urology for example, the service had submitted a business case for a urology consultant and reviewing the Thursday list. The trust was also investing in training nursing staff to perform urodynamics (a test to understand how the bladder and urethra are performing their job of storing and releasing urine).

The trust was looking at other ways to manage theatre list. Patients who were open to having their procedures moved forward if an earlier date became available were given the opportunity to be placed on special waiting lists. These were already live in urology and orthopaedics, where they were discussed during weekly theatre utilisation meetings. They plan to roll this out across other specialities, allowing more patients the opportunity to be put on a short call list.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff started discharge planning during the pre-assessment process for patients having elective operations. Staff told us they discussed discharge with patients during the pre-assessment, so the service could start planning any additional support the patient might need following surgery.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had put arrangement in place as part of their winter pressure management, trauma and orthopaedic patients were transferred to a rehabilitation centre following their surgery.

The operating theatres had developed elective paediatric list which occurred all day on Mondays and Friday morning. This ensured they had paediatric trained nurses to care for these patients and included bank nurses in recovery.

The service was reviewing their day case pathways for ENT and key hole surgery for gall bladder for example which did not necessarily require an overnight stay. A senior staff told us they were working with the surgeons to develop an agreed pathway which would concentrate on patients' needs, profiles and type of surgery. The aim was to improve consistency in the way that care was delivered.

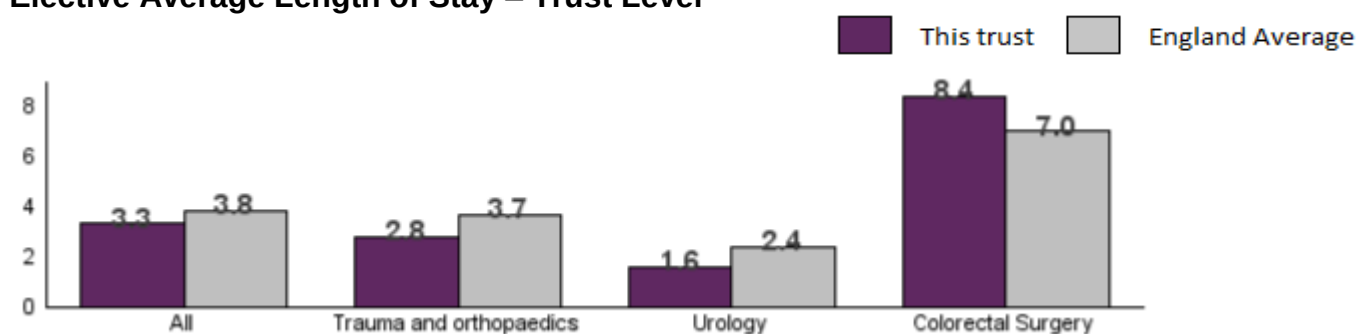
Data received from the trust showed that between January to December 2019 theatre utilisation had been between 80% to 90%. Bed occupancy during the same period varied between 90% and 95%.

Trust Level – elective patients

From July 2018 to June 2019 the average length of stay for patients having elective surgery at the trust was 3.3 days. The average for England was 3.8 days.

- The average length of stay for patients having elective trauma and orthopaedics surgery at the trust was 2.8 days. The average for England was 3.7 days.
- The average length of stay for patients having elective urology surgery at the trust was 1.6 days. The average for England was 2.4 days.
- The average length of stay for patients having elective colorectal surgery at the trust was 8.4 days. The average for England was 7.0 days.

Elective Average Length of Stay – Trust Level



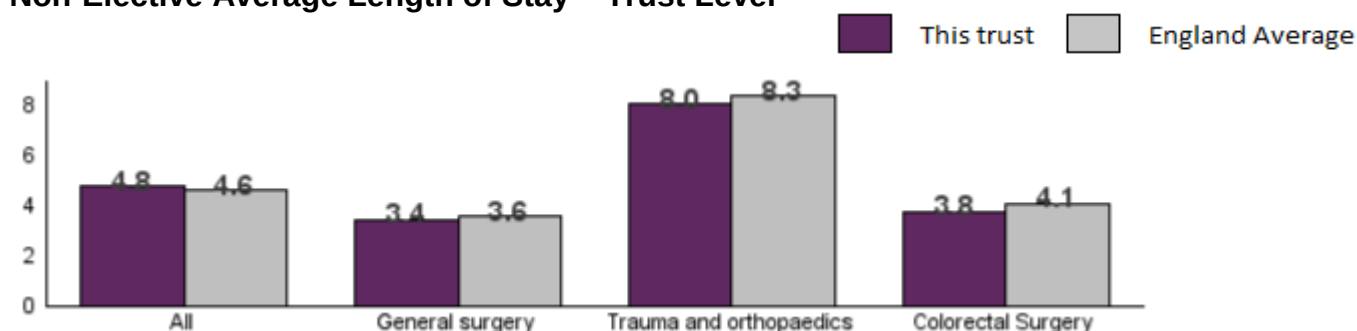
Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for patients having non-elective surgery at the trust was 4.8 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective general surgery at the trust was 3.4 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at the trust was 8.0 days. The average for England was 8.3 days.
- The average length of stay for patients having non-elective colorectal surgery at the trust was 3.8 days. The average for England was 4.1 days.

Non-Elective Average Length of Stay – Trust Level



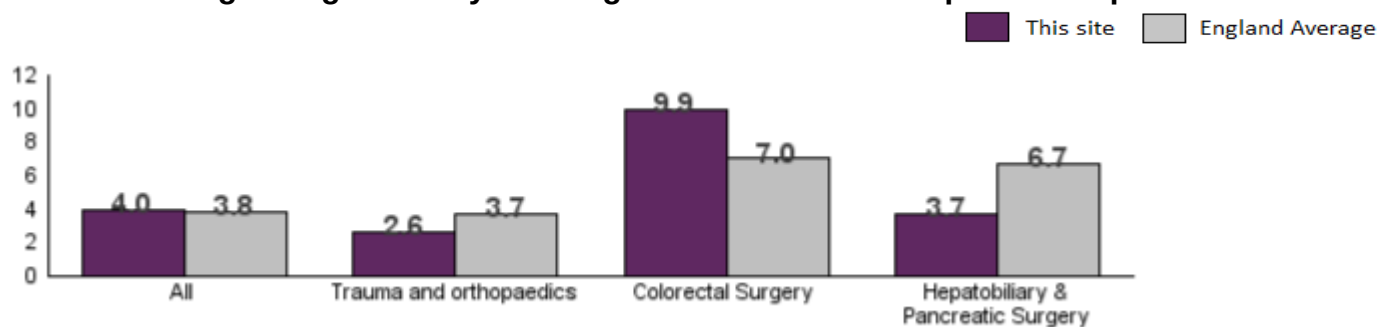
Note: Top three specialties for specific trust based on count of activity.

Basingstoke and North Hampshire Hospital - elective patients

From July 2018 to June 2019 the average length of stay for patients having elective surgery at Basingstoke and North Hampshire Hospital was 4.0 days. The average for England was 3.8 days.

- The average length of stay for patients having elective trauma and orthopaedics surgery at Basingstoke and North Hampshire Hospital was 2.6 days. The average for England was 3.7 days.
- The average length of stay for patients having elective colorectal surgery at Basingstoke and North Hampshire Hospital was 9.9 days. The average for England was 7.0 days.
- The average length of stay for patients having elective hepatobiliary and pancreatic surgery at Basingstoke and North Hampshire Hospital was 3.7 days. The average for England was 6.7 days.

Elective Average Length of Stay - Basingstoke and North Hampshire Hospital



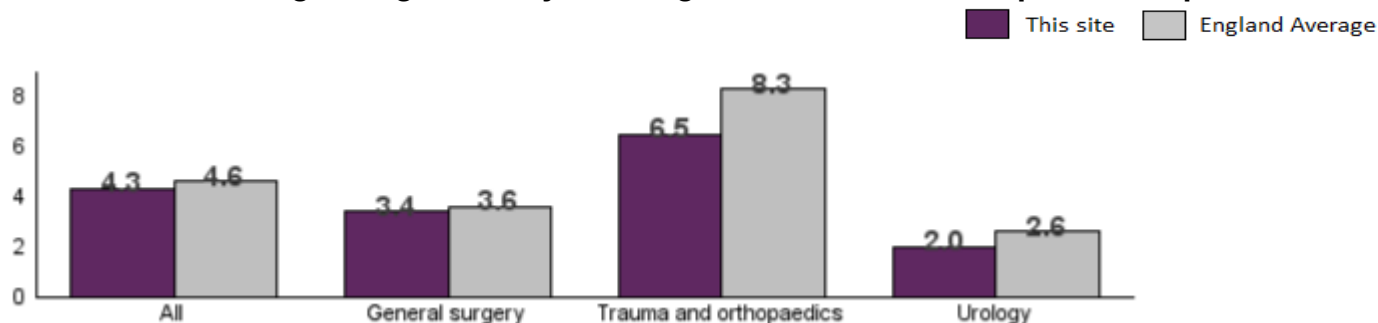
Note: Top three specialties for specific site based on count of activity.

Basingstoke and North Hampshire Hospital - non-elective patients

The average length of stay for patients having non-elective surgery at Basingstoke and North Hampshire Hospital was 4.3 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective general surgery at Basingstoke and North Hampshire Hospital was 3.4 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at Basingstoke and North Hampshire Hospital was 6.5 days. The average for England was 8.3 days.
- The average length of stay for patients having non-elective urology surgery at Basingstoke and North Hampshire Hospital was 2.0 days. The average for England was 2.6 days.

Non-Elective Average Length of Stay - Basingstoke and North Hampshire Hospital

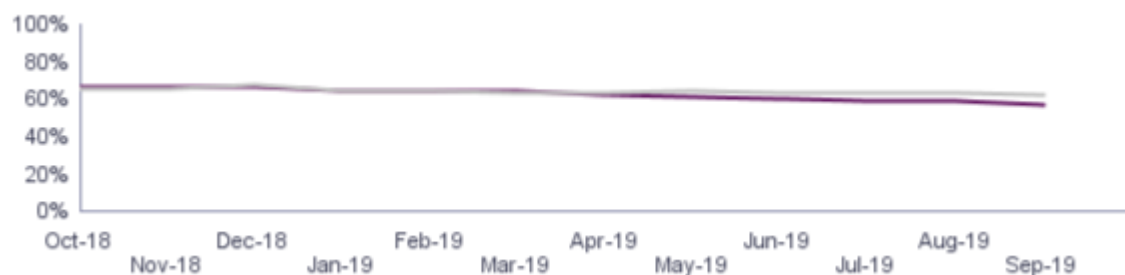


Note: Top three specialties for specific site based on count of activity.

Referral to treatment (percentage within 18 weeks) - admitted performance

From October 2018 to September 2019 the trust's referral to treatment time (RTT) for admitted pathways for surgery was largely in line with the England average from October 2018 to September 2019. The trust's performance ranged from 56.5% to 66.7%, while the England average ranged from 62.3% to 68.3%.

— This Trust — England Avg.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Two specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
General surgery	76.6%	71.9%
Trauma and orthopaedics	64.4%	57.9%

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	66.9%	74.3%
Ear, Nose and Throat (ENT)	55.8%	59.7%
Ophthalmology	49.3%	61.0%

The Surgical division held weekly waiting list management meetings at care group and divisional level. General Surgery referral to treatment time (RTT) current performance was 83.9%.

The trust told us they had key actions to address performance including putting forward a case for increased emergency surgeon consultant cover. They were working with the trust's overall strategy to introduce medical rota and working with the transformational programme to streamline pre-assessment.

Senior staff members we spoke with told us this was high on the trust's agenda to reduce waiting times and actions were in place. The surgical division held weekly waiting list management meetings at care group and divisional level. The trust recognised the key reasons for this included a gap in capacity to perform laparoscopic cholecystectomy and hot gall bladders within the emergency surgery consultant team. A lack of clear job planning to ensure agreed activity and shift of referrals being coded under Colorectal reducing the number of new referrals under 18 weeks in general surgery.

For urology, the trust told us this was due to budgetary restrictions and were unable to utilise other means to clear long waiters. They had weekly diary meeting to review long waiters and book cases in a timely manner but only had limited capacity to book into.

Cancelled operations

Managers worked to keep the number of cancelled appointments and operations to a minimum.

When patients had their appointments and operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

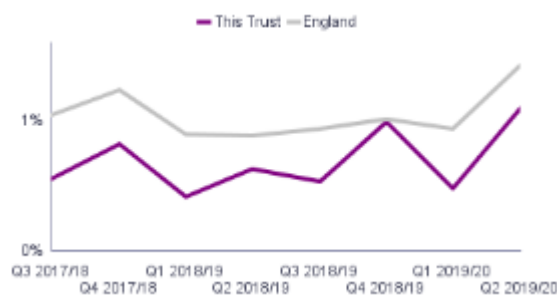
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Over the two years, the percentage of cancelled operations at the trust showed that trust performance was better than the England average in three quarters, the same in same in two and worse in one quarter. In Q1 2017/18 and Q3 2017/18 the highest percentages of cancelled operations were reported with 11% and 10% of operations cancelled respectively.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Hampshire Hospitals NHS Foundation Trust



Cancelled operations as a percentage of elective admissions - Hampshire Hospitals NHS Foundation Trust



Over the two years, the percentage of cancelled operations at the trust were mostly better (lower) than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Managers monitored that patient moves between wards/services were kept to a minimum. Managers told us that they moved patients only when there was a clear medical reason. We saw that medical patients who were outliers had been nursed in designated surgical ward which minimised patients' moves to different wards.

Managers and staff worked to make sure that they started discharge planning as early as possible. Patients records contained information about the proposed length of stay and allied health staff assessed patients' needs for equipment post-surgery to ensure equipment was available to them

and not to delay the patients' discharge. However; staff told us the discharge of patients was a major concern due to the lack of social care beds and the frailty of patients.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs and liaised with the community mental health team.

Managers monitored the number of delayed discharges, knew which wards had the highest number and acted to prevent them. The data on patients moves showed the service was managing this well. Staff supported patients when they were referred or transferred between services and relied on the support from the multi-disciplinary team in particular for patients who were outliers on the surgical wards.

Patient moving wards per admission

The trust was asked to report ward moves for the top five inpatients wards across all services at the trust. From October 2018 to September 2019, none of the surgical wards were ranked within the top five inpatient wards.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

The trust was asked to report ward moves at night for the top five inpatients wards across all services at the trust. From October 2018 to September 2019, none of the surgical wards were ranked within the top five inpatient wards.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We saw leaflets were available on how to raise a concern or complaint and this was available in different formats if required. Patients we spoke with told us they were happy with their care and some of them said they would approach 'the nurse in charge or may be the matron' if they had any concerns.

Staff understood the policy on complaints and knew how to handle them. Staff said they did not receive many complaints; however, they would escalate these to the matron and address minor concerns at the time.

Managers investigated complaints and identified themes. Complaints were reviewed by the Quality and Performance Committee. The quarterly quality account report for October to December 2019 showed the top 3 complaint themes for surgery were communication, clinical treatment and appointments.

The trust told us that as well as the complainant receiving an apology and explanation, the following learning/action had taken place in response to complaints received. This included moving to electronic diaries to manage clinical leave and commitments, staff training regarding communicating with patients and different approach to assisting patients. The service was looking at developing information leaflets to take home following laparoscopic procedures on C3 ward. A

senior staff told us that matron ward rounds had been introduced on D4 ward to ensure a senior nurse reviews each patient daily.

We saw a number of thank you cards were displayed in the wards which staff told us they were proud of and meant a lot to them. The surgical services displayed 'you said...we did', boards and these had positive comments.

However; we asked staff for an example of changes in practice following complaints and we did not receive any.

Summary of complaints

Trust level

From October 2018 to September 2019 the trust received 164 complaints in relation to surgery at the trust (16% of total complaints received by the trust). The trust took an average of 27.8 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be investigated and closed within 25 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	56	34.1%
Communication	31	18.9%
Admissions and discharges	19	11.6%
Patient care	19	11.6%
Values and behaviour	18	11.0%
Appointments	8	4.9%
Trust admin/policies/procedures	3	1.8%
Waiting times	3	1.8%
Access to treatment and drugs	2	1.2%
Other	2	1.2%
PDW	2	1.2%
Prescribing	1	0.6%
Total	164	100.0%

Basingstoke and North Hampshire Hospital

From October 2018 to September 2019 the trust received 71 complaints in relation to surgery at Basingstoke and North Hampshire Hospital. The trust took an average of 11.8 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be investigated and closed within 25 working days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	21	28.4%
Communication	17	23.0%
Patient care	13	18.3%
Admissions and discharges	11	15.5%
Values and behaviour	4	5.6%

Appointments	2	2.8%
Access to treatment and drugs	1	1.4%
Other	1	1.4%
PDW	1	1.4%
Trust admin/policies/procedures	1	1.4%
Waiting times	1	1.4%
Total	74	100.0%

There were 48 complaints about surgery where no sites were allocated.

Number of compliments made to the trust

From October 2018 to September 2019 there were 41 compliments received for surgery at the trust (15.8% of all received trust wide).

A breakdown of compliments by site is shown below. There were no compliments received for Andover War Memorial Hospital:

Site	Number of compliments	Percentage of total
Basingstoke and North Hampshire Hospital	22	53.7%
Royal Hampshire County Hospital	19	46.3%
Total	41	100.0%

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

Is the service well-led?

Leadership

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

The trust services were organised into three clinical divisions; surgical services, medical services and family and clinical support services. The surgical service was led by a medical director who was supported by an operations director. They were supported by the clinical and corporate service teams.

Each service had a clinical director, a clinical lead, a directorate manager and a matron who were responsible for the delivery of services. In addition, ward managers were employed to support the daily running of the wards.

We were told that leadership and development opportunities were available to the staff. For example, ward managers new in post were able to attend a management course to prepare them for their new role.

We met with the managers during the inspection and found they were organised and demonstrated supportive leadership. They had a good understanding of issues, challenges and priorities of their service. They were knowledgeable about the ward's performance against the

trust priorities and the areas for improvement. Matrons supported the ward managers and staff, we observed they were on the wards and staff told us the matrons visited the wards regularly.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's vision was to provide outstanding care for every patient this was underpinned by their CARE values which translated as:

- Compassion, caring about our patients and our staff.
- Accountable and responsible, always improving.
- Respect for all colleagues, patients and their families.
- Encouraging and challenging each other to always do your best.

Staff we spoke with were aware of the trust's values and staff told us the whole team contributed to providing caring and compassionate care for the patients. Progress in the implementation of priorities and delivering the trust's strategy was monitored by the executive board with input from the care groups.

The visions and strategy for surgery was to reconfigure the trauma and orthopaedic service to provide improved facilities as well as enhanced clinical support to meet the complex needs of this patient's group. The service recognised that surgeons specialised in different types of complex orthopaedic surgery and to ensure that the service could be delivered seven days a week. Managers were fully committed into driving the implementation and we were told there was a plan to audit this later this year.

This included additional ortho-geriatric support to optimise the frail elderly as well as additional occupational therapy and physiotherapy resources to improve rehabilitation and minimise deconditioning of patients during their hospital stay.

The trauma /orthopaedic services had been effectively transferred to the Basingstoke site and staff we spoke with had been positive about this change. Managers told us this was work in progress and were aware of the challenges and priorities for this service.

Staff we spoke with knew how their work contributed to the wider vision of the trust and they were aware of the trust's values. Staff told us how the trust's vision and strategy was included in their work and delivering safe and effective care.

For 2019/20, the trust's priorities were developed through a number of workshops and engagement with the board of directors, governors, staff groups and with the senior leadership team. This was then distributed to staff, stakeholders and the public through a survey monkey and over 1000 people responded with their priority order for the objectives.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with which included nursing, medical and allied health care described their culture as being supportive and respectful to colleagues. Staff said they felt there was a positive culture which 'makes it a good place to work'.

Newly recruited staff told us they felt supported and valued by their new team. The service had an open culture where patients, their families and staff could raise concerns without fear. A senior manager told us about the recent work had been done to raise the profile and getting staff engaged in this.

Staff in the surgical services we visited said they had excellent teamwork amongst their colleagues. They were open and honest and acknowledged staff shortages could sometimes make work challenging. However, in C2 staff said they were an established team and worked together to provide the best care to patients and safely.

The staff said they felt part of the larger trust and senior managers were visible and supportive. There were supportive relationships amongst staff, and we observed good morale and staff satisfaction.

The service promoted equality and diversity in daily work and staff told us they were encouraged to apply for internal promotion. There was a development programme for band five and six nurses to support these staff in their career progression. The trust had an apprenticeship programme and had their first cohort of apprentices nearing completion, they plan to commission an external provider to complete the final assessments. The trust was looking at the senior health care worker qualification, the learner starting at level 2 and progress to level 3 which was the entry level for the nursing degree.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service.

The surgical division was made of a triumvirate of medical, nursing and operations who worked together as the senior management team. The surgical services were represented by the clinical director, risk managers, operational service manager and clinical matrons as part of the surgical management team.

We reviewed governance meeting minutes for October 2019 from the surgical board performance report meeting. They reviewed the RTT performance within orthopaedics which was a focus and recognised as a significant concern. VTE had been amber for the previous three months; a re-focus was required on these and other assessments to ensure they were being completed.

Policies and procedures were standard items which were discussed at the governance meetings. The policies which included infection control and management of suspected or confirmed tuberculosis, medicine formulary, mental capacity act and norovirus and diarrhoea and vomiting management were reviewed within the division and had been circulated to board members.

The governance meetings included standing agenda items including; mortality and morbidity reviews, national best practice clinical guidance, clinical audits and quality improvements,

incidents, complaints and compliments and risk register review. Managers and clinical leads also reviewed clinical learning at morbidity and mortality meetings, which were held monthly. This ensured that clinical practice continuously improved.

The service held regular senior management team meetings, which monitored progress on achieving strategic aims. Monthly operational group meetings monitored progress on the operational strategy.

The clinical governance group held meetings monthly. They had clear terms of reference, which included reviewing the operational risk register, reviewing the operational scorecard, monitoring the clinical governance work plan, reviewing national clinical guidance, and shared learning.

The trust had redesigned their trauma /orthopaedic services. The “Getting it Right First Time” (GIRFT) Review in July 2018 led by Professor Briggs supported a number of changes to the trust trauma and orthopaedic services. A range of options were considered in the development of the proposals for the reconfiguration of orthopaedic services to deliver the outcomes and objectives. One of the aims was to establish a centre of excellence for Hip and Knee Arthroplasty, addressing variation in patient numbers and outcomes for elective joint surgery.

Managers told us the trust was working to improve access to ortho-geriatric cover to reduce 30-day mortality rates and length of stay following fractured neck of femur operations as both acute sites had been reported as national outliers. Staff at all levels were aware of their responsibilities and the part they played in providing safe and effective care. Staff gave examples such as the effective triaging at pre- operative assessment stage and raising any patients concerns with the anaesthetist. Ward staff ensured the pre- operative checklist was fully completed to include allergies to safeguard patients. Patients who were undergoing major bowel surgery had robust pre-operative process which staff followed including bowel preparation and review by dietitians to start feeding regimes post-surgery.

Managers discussed that information from meetings was disseminated to ward staff such as at staff meetings, handovers, safety huddles, via emails and newsletters. We reviewed staff meeting minutes and noted this was covered. Staff said they attended ward meetings and we saw meeting minutes were available for staff.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had oversight of risks at local, care group and divisional level. The care groups regularly reviewed risk registers and updated them with actions taken to reduce risks and any changes in risk ratings. The service held local risk registers for theatres and wards. These fed into care group risk registers, and further upwards into divisional risk registers. The divisional risk registers fed into the trust-level risk register.

We saw examples of colorectal risk register- where the trust had identified a lack of pelvic floor physio support resulting in patients on the list with no service to go to. Actions were considered and included short term review of cases and a business case was submitted and patients were referred to an external service for support.

The surgical services followed their process of monitoring for return to theatre and this was reported nationally. They return to theatre rate set at 5% for their work and if that was exceeded, it was discussed at performance review meetings.

Service risks were regularly reviewed, and plans were put in place to mitigate against them. The risk register was a working document, this included the date risks were added, review dates, and allocated staff who owned these risks. Minutes of November 2019 governance board meeting highlighted a risk as the trust did not have the most up to date version of electronic record system. The lack of an interface with primary medical services (PMS) meant that waits might not be accurately measured when appointments were booked manually and the trust was looking at an upgrade in the new year which would address this. The team was presented with the new thromboprophylaxis policy for comment, to ensure that all implications were factored in before it was adopted.

The trust risk register identified the lack of capacity to deliver triage of straight to colonoscopy test for 28-day pathway and this was rated red. The trust review found this was due to CNS capacity at present. They had mitigated this risk and planning to use Wessex funding once approved to support this model and meet the referral to treatment time.

The trust was reviewing their underperformance against planned income targets by increasing theatre productivity through maximised list utilisation and increased activity.

The trust had a process for reviewing deaths that occurred at the service. There was a learning from death's policy which in line with the national guidance and a structured review process.

The service had a planned audit programme which included reviews of the world health organisation (WHO) checklist, venous thromboembolism (VTE), infection control and hand audits. All these were to ensure care was provided safely and reducing the risk of harm to patients, reducing financial pressures without compromising the quality of care. Managers also reviewed their staffing and agency usage, offering staff on the bank and regular staff to cover any shortfalls in staffing in order to reduce high agency costs.

Theatres had implemented the National Safety Standards for Invasive Procedures (NatSSIPs) within Local Safety Standards for Invasive Procedures (LocSSIPs). The NatSSIPs contain 13 key standards which cover all aspects of the patient journey throughout an invasive procedure, ensuring safety checks were performed by the team providing care at every critical step in the pathway. NHS Improvement published the National Safety Standards for Invasive Procedures (NatSSIPs) in September 2015 to help NHS organisations provide safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical never events can occur. Staff in theatres followed Local Safety Standards for Invasive Procedures (LocSSIPs) when carrying out the World Health Organisation Surgical Safety Checklist. This included briefing at the start of the procedure and included process for checking implants for surgery.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The trust had a mortality screening tool which clinical staff used for learning from deaths. The investigation was presented at the mortality surveillance group which undertook scrutiny of the review, the findings, any recommendation and learning was identified.

The trust mortality review process was continuously developing, the screening and reviews were linked with the electronic patient record. This had led to improved links with partner organisations such as prison services and private hospitals.

Managers used their performance dashboard and assurance reports for the most recent data. This was assessed and used to improve the service delivery. For example, following analysis of data for venous thromboembolism (VTE), staff were reminded to complete the electronic risk assessment with 24 hours of admission.

The trust took part in the data security and protection toolkit, which was a self-assessment audit completed by all NHS trusts and submitted to NHS Digital. The aim was to provide assurance annually of an organisation's information governance practices against the national data security standards.

Staff were able to access information on their local intranet, which included clinical policies and standard operating procedures. There was also information such as patient information leaflets to support a patient giving informed consent, which staff could print for the intranet. For example, information about joint replacement, various surgical procedures were available. However, there were policies which were held on the wards in paper formats. These had not been reviewed and updated in line with the trust policy which may pose risk of staff using out of date information.

The patient, on discharge, received a letter that included details of their surgical procedure, findings, medication and any changes and details of any follow up. The nurse sent a copy of this letter to the GP and placed a copy in the patient's medical records at the hospital. The medical staff were able to access patient's information, including scan results and blood tests using the hospitals information technology systems.

The trust had a Health Information Point (HiP) which was a free and confidential service located at Basingstoke and North Hampshire Hospital. This provided a service for patients, carers, visitors and staff within the communities served by the Trust. The HiP responded to queries about medical conditions, tests, treatments and healthy lifestyles and provided details of local and national support groups. The HiP also promoted public health initiatives supporting national awareness campaigns throughout the year. The trust told us they also had a virtual readers group to review patients' information and give their feedback to ensure information was accessible for the patients, relatives and carers.

Engagement

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

The trust actively engaged with the local community, the volunteers who provided invaluable support to the services. The friends and family test showed that overall 94% of patients would recommend the Trust to friends and family should they need similar care or treatment.

Between August 2018 and January 2019, the CQC undertook an inpatient survey at the trust. A questionnaire was sent to 1,250 recent inpatients. The survey looked at the experiences of people

who were discharged from an NHS acute hospital in July 2018. Responses were received from 605 patients at Hampshire Hospitals NHS Foundation Trust. The result showed the trust was performing about the same as most other trusts that took part in the survey.

The trust was responsive to patients' feedback to improve the service provision. Other actions from patients' surveys included looking at the potential transport options available. For example, extending park and ride times, negotiating reduced fees with transport providers for frequent visitors, working with the voluntary sector or existing patient transport to increase operational times.

The trust website provided a variety of information for the public. The trust consulted with the staff, public and patients when they were planning to centralise some of the trauma and orthopaedic services from Hampshire site to Basingstoke hospital. They were aware of the impact that these proposals might have on people using the service. The trust website contained information on how people could provide their feedback. The trust had arrangements in place and opportunity for people to give their feedback verbally.

Staff told us about the national programme that the trust had adopted which recognised excellent service called the "Wow" awards. Nominations were made by patients or staff in five categories. We saw posters in various wards where these were displayed, and the staff who had recently received this award. The staff told us they were 'very proud' of receiving the nominations and recognition of their work.

The NHS staff survey published in February 2019 reported 92% of staff at the trust, felt trusted to do their job, while 90% said that their role made a difference to patients. Also 78% per cent of people working at the trust they would recommend it as a place to work. This was above the national average, believe that the care of patients remained the trust's top priority. The trust used the data from the pay gap report published in 2019 to review how they could attract women into the organisation and explored options to provide unconscious bias training for staff.

The trust had developed an action plan from the result of the survey and were to provide additional support for staff in management or supervisor roles because of feedback from the survey. This included looking at more ways for staff to be innovative and change things for the better. A senior manager told us the trust was working hard to recruit additional staff, as they recognised staffing was an area that needed to be constantly reviewed.

The service promoted equality and diversity in their daily work which a staff member said was to respect your colleagues, patients and their family. The trust launched an inclusivity network in 2018 which met bi-monthly where staff could meet up and discuss matters of equality, diversity and inclusivity. The forum also fed into the trust's equality, diversity and inclusivity steering group.

The trust worked in partnership with Stonewall through the health champions programme to better understand the health and wellbeing needs of Lesbian Gay, Bi sexual, Transgender (LGBT) to ensure the services were accessible and considered their needs.

The trust had introduced a cultural change ambassador. They were looking at changes to parking and a workstream was in progress. The team was looking to add a patient cultural change ambassador to increase the diversity of thinking.

Learning, continuous improvement and innovation

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

The trust is one of three centres in the UK to provide a service for the assessment and management of patients with Pseudomyxoma Peritonei (a rare malignant growth characterized by the progressive accumulation of mucus-secreting (mucinous) tumour cells within the abdomen and pelvis).

The trust also provided a specialised service for the assessment and management of patients with colorectal peritoneal malignancy commissioned by NHS England since 2013.

As part of the care improvement work the trust had increased the capacity for treatment for pseudomyxoma at the hospital.

The trauma and orthopaedic service had been relocated at Basingstoke site to improve access for patients undergoing elective surgery. This would be achieved by reducing cancellations of planned operations due to competing non-elective demands for beds and theatre capacity.

The trust had started an efficiency project for their pre-assessment processes and theatre utilisation so that fewer patients have appointments cancelled or delayed.

The trust had started developing a new surgery assessment unit on the Basingstoke site to support the faster treatment of patients in the most appropriate setting.

The trust had a well-established quality improvement (QI) team following a training programme last year. There were QI champions to support the QI programme.