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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

WEDNESDAY, 22 JULY 2015 AT 9.30 AM

CONFERENCE ROOM A - SECOND FLOOR, CIVIC OFFICES

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Membership

Councillor John Ferrett (Chair)
Councillor Phil Smith (Vice-Chair)
Councillor Jennie Brent
Councillor Alicia Denny
Councillor Gemma New
Councillor Lynne Stagg
Councillor Brian Bayford
Councillor Gwen Blackett
Councillor Peter Edgar
Councillor David Keast
Councillor Mike Read

Standing Deputies

Councillor Ryan Brent
Councillor Margaret Foster
Councillor Aiden Gray
Councillor Hannah Hockaday
Councillor Lee Hunt
Councillor Ian Lyon
Councillor Sandra Stockdale

(NB This agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meeting (Pages 1 - 4)

4 **Urgent Care and Walk in Centres** (Pages 5 - 24)

The panel will consider the attached reports from:

Innes Richens, Chief Operating Officer, Portsmouth Clinical Commissioning Group

Paul Fisher, Minor Injuries Unit/ Minor Illnesses Unit Service Manager, Penny Daniels, Hospital Director and Dr Deb Jeavans-Fellowes, Operations Manager, St Mary's Walk In Centre.

The panel will also hear from Kim Dennis, Service Manager, Guildhall Walk Healthcare Centre whose report is to follow.

5 **PHT update including the Care Quality Commission's Inspection report on Queen Alexandra Hospital** (Pages 25 - 82)

Ursula Ward, Chief Executive Portsmouth Hospitals' NHS Trust will present the attached letter.

6 **Tamerine Respite Care Unit.** (Pages 83 - 86)

Carol Cleary, Interim Head of Services TQ2 will present the attached report.

7 **Healthwatch Annual Report** (Pages 87 - 108)

Carol Elliott, Head of Development and Patrick Fowler will answer questions on the attached report.

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue.

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HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Tuesday, 16 June 2015 at 9.30am in the Guildhall

Present

Councillor John Ferrett (Chair)
Phil Smith
Jennie Brent
Alicia Denny
Gemma New
Lynne Stagg
Gwen Blackett, Havant Borough Council
Peter Edgar, Gosport Borough Council
Mike Read, Winchester Borough Council

Also in Attendance

Portsmouth Clinical Commissioning Group
Innes Richens, Chief Operating Officer,
Dr Tim Wilkinson, Clinical Executive,

1. Welcome and Apologies for Absence (AI 1)

Apologies were received from Councillor Bayford.

Members asked that their thanks be passed on to David Horne for his great diligence and very contentious work as Chair.

2. Declarations of Members' Interests (AI 2)

Councillors Peter Edgar and Gwen Blackett declared the following non-prejudicial interests: they are Governors at Portsmouth Hospitals' NHS Trust.

3. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes from the meeting held on 24 March 2015 be confirmed as a correct record.

Matters Arising

Councillor Read requested further information on oral health talks given to carers and people in residential care.

4. Urgent Care and Walk in Centres - report from Portsmouth CCG (AI 4)

Alan Banting, Chair of Pompey Pensioners gave a deputation in support of keeping the Guildhall Walk Healthcare Centre which included the following points:

- He has been a registered patient at Guildhall Walk Healthcare Centre (GHW) for five years.
- He is very happy with the flexibility of access and that the doctor comes to the waiting area to call the patients.
- He recommended that the panel read Monitor's recent review of centres.

Innes Richens and Dr Tim Wilkinson introduced the report and the summary of engagement activity which had been circulated with the agenda and added the following points:

- The CCG is mid-way through the engagement process and no decision would be made until this was completed.
- GPs support the minor injuries unit at St Mary's Hospital but have mixed views regarding the minor illness unit.
- There is some evidence that a number of patients are being referred to their own GP.
- GPs prefer to see their own patients.
- Co-locating the two walk-in services would strengthen the service.
- The CCG will continue working with all GP practices to extend access to primary care.
- It is committed to providing primary care service for homeless if the GHW were to be closed.
- A survey has been sent to all patients registered at GHW.

In response to questions from the panel, the following points were clarified:

- The CCG is meeting with the university to discuss the needs of their students.
- The GHW is used by many people who live outside the city but work in the city centre.
- The majority of people use it as a walk-in service but are registered elsewhere. This means that the commissioners pay twice.
- Both walk-in centres are seeing the number of patients that they are contracted to.
- If the GHW walk in service were to be moved to St May's the CCG would commission the same level of activity.
- All GP practices offer same day appointments by employing different methods.
- There are good transport routes to St Mary's Hospital.
- Some GP practices have indicated that they would be able to accept more patients if the GHW were to be closed.
- An Equalities Impact Assessment was completed in 2010 and another one is currently being discussed and will be carried out.
- Patients generally report good access to their GPs and 80 are happy with the access. A small number prefer to attend A&E rather than wait to be seen at their GP practice.
- Work is being carried out to encourage GPs to work together to increase accessibility.
- Patients are happy to see any GP as long as they have access to their records.
- A GP practice can close its list to new patients only with permission from the CQC.
- In Portsmouth a significant number of GPs and Practice Nurses are approaching retirement within 3 or 4 years' time. There are not enough in the pipeline to replace them. This reflects the national picture. Federation working is one of the possible solutions being discussed.
- All practices offer same day access in different ways.

- Front line staff are under pressure dealing with the demand for same day appointments. If a patient needs to be seen, they should be.
- Feedback from GP Practice Participation Groups is very important.
- The nonattendance rate in the city is 8%.
- According to the last survey, there are between 1,000-1,100 homeless people in the city. There used to be one GP practice in the city that specialised in offering services to homeless patients. The CCG is currently discussing their needs with the Salvation Army and other agencies.
- The GHW is the only practice that offers a seven day service.
- Last Christmas, a weekend service at some GPs was commissioned with national funding. The take up was very low. This may be because people are not used to it.
- There are clear patterns of usage for the GHW.
- If the contract were to be extended it would possibly be for another five years.
- 40% of GP training positions are not taken up.

Members made the following comments:

- Travelling by bus from East to West in the city is not as easy as from North to South.
- More and more university accommodation is being built in the city centre.
- It is important to hear what patients say about the proposals.
- Having one pattern for urgent care would benefit the whole area.
- A large number of patients are turned away from the Minor Injuries Unit at the War Memorial Hospital.
- The limited resources must be spent wisely.
- Having a GP presence at St Mary's walk-in centre would make the service more efficient.
- It is not clear that there would be sufficient capacity at other GP practices to take on the patients from GHW were it to close. This could lead to people not registering with a GP.

Actions

- Visits will be arranged to the GHW and St Mary's Minor Injuries Unit before the next HOSP meeting.
- An information paper on GP commissioning be provided to the HOSP.

5. Dates of Future Meetings (AI 5)

RESOLVED that the following meeting dates be agreed:
22 July
1 September
3 November

The meeting ended at 10.45am.

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NHS
Portsmouth
Clinical Commissioning Group

Guildhall Walk Healthcare Centre

Briefing update for members of the Portsmouth Health Overview and Scrutiny Panel – July 2015

1. Introduction

Following the Portsmouth Health Overview and Scrutiny Panel meeting on June 16th 2015, NHS Portsmouth Clinical Commissioning Group has been further refining its proposals for the walk in and GP practice services at the Guildhall Walk Healthcare Centre (GWHC) and has continued its engagement activity to seek feedback from local people about the current proposals.

The NHS Portsmouth CCG Governing Board received an updated briefing at its meeting in public on Wednesday 15th July 2015 and this forms the basis of this update paper for HOSP members. The information that follows provides more detail about the proposals and the reasons for developing them, as well as offering an update on current progress with our local engagement activity.

2. Background

GWHC is located in Portsmouth City Centre and provides two component services under a single contract: primary medical care services for registered patients; and a GP-led Walk in Centre service for both registered and unregistered patients. This is currently provided by Portsmouth Health Limited (PHL) through an Alternative Provider Medical Services (APMS) contract, which is subcontracted to be delivered by Care UK. It has a registered raw patient population of 5,921 (as of April 2015), which consists of a diverse demographic including, among other cohorts of patients, students from the University of Portsmouth, homeless people, and people with a history of alcohol and/or drug misuse.

The service was set up by NHS Portsmouth Primary Care Trust (PCT) as an Equitable Access Centre (or 'Darzi Centre') in 2009, providing services from 08:00-20:00, 365 days a year. Following the NHS reforms that came into effect in 2013, NHS Portsmouth CCG has responsibility for the commissioning of unscheduled care across the city, and as such has oversight of the PHL contract related to the walk in service service at GWHC. Although NHS England had assumed commissioning responsibility for the primary medical care service element of the contract for the registered patient population in 2013, following a Scheme of Delegation Agreement signed by both NHS England and NHS Portsmouth CCG, Portsmouth CCG now have delegated commissioning responsibility for the whole GWHC contract (as of 1st April 2015).

The original contract was awarded for a five year period. This was due to expire on the 31st July 2014; however, this was later extended until the 31st July 2015, and another extension has now been issued until the 31st March 2016. A decision now needs to be made as to what elements of service provision from the GWHC contract will be commissioned beyond this point, and how that service provision will be configured in relation to the wider healthcare system.

13/14 Costs to Portsmouth CCG
The costs incurred for 14/15 for GHW are in the process of being confirmed. Therefore for figures for 13/14 for GHW are presented here. As a comparison the costs for the St Marys Walk In Centre are also given:

Urgent Care Provision

St Marys Minor injuries Unit	£1.2m
St Marys Minor illness service (nurse led)	£0.4m
GHW GP led walk in	£0.7m
Total Urgent Care Provision	**£2.3m**

Primary care provision

GHW registered list (GP Practice)	£0.6m

3. Care Provision in Portsmouth City

The current configuration of Urgent Care Services within Portsmouth City has built up gradually over the years in response to both external and internal influences. Currently, and historically, local commissioning organisations have had to respond to national policies (for example, the procurement of “Darzi centres” and Independent Sector Treatment Centres); however, we have also, in collaboration with local healthcare partners, evolved in response to local demand (for example, the establishment of the Urgent Care Centre at Queen Alexandra Hospital). The result of which is that patients within Portsmouth City have to choose between a number of different services when seeking care urgently.

3.1. Current Configuration of Urgent and Primary Care Services

Detailed below is an overview of services currently commissioned within Portsmouth that meet the population’s urgent care and primary care needs, and serves to highlight how patients can access a variety of care.

Urgent Care
Presently there are two separate WICs located within the city. One WIC is located at the St Mary’s Treatment Centre and manages both minor injuries and minor illness; this is a nurse-led service open from 07:30-22:00 Monday-Friday, and 08:00-22:00 at weekends and Bank Holidays. Another WIC is located at GWHC and manages minor illnesses only; this is a GP-led service (with support from nurses) open from 08:00-20:00 365 days a year.

There is also an Urgent Care Centre located at Queen Alexandra hospital which manages both minor injuries and minor illnesses; this is a GP-led service (with support from nurses). In addition to these services the NHS 111 telephone service also provides signposting to services and advice to patients who have an urgent care need.

Primary Care
NHS Portsmouth CCG currently has 23 member GP practices operating out of 31 sites across the city. In addition to their core opening hours (08:00-18:30, Monday-Friday), 22 member practices also offer patients extended access through additional clinics either in the early morning (before 08:00) or late evening (after 18:30) during weekdays, or through additional clinics on Saturdays; this is dependent on patient preference within individual surgeries.

GWHC are unique in that they are the only surgery in Portsmouth contracted to provide access to their registered patients between 08:00-20:00, 365 days of the year. This was

stipulated in their APMS contract when it was first awarded in 2009 and they are paid more per patient than a practice with normal core opening hours to reflect this.

All GP practices in Portsmouth also offer same day access for patients with urgent primary care needs.

In addition to in-hours GP service provision (08:00-18:30), Portsmouth patients also have access to an out-of-hours GP service between 18:30-08:00 on weekdays, and 24 hours a day at weekends and on bank holidays. Access to GP Out of hours is determined on the outcome of clinical pathways operated by NHS 111.

Pharmacies are another important access point to primary care within Portsmouth city; currently all 41 pharmacies within Portsmouth are commissioned to deliver at least one enhanced service with many providing multiple enhanced services.

3.2. Walk-In Centre Activity

Detailed below is an overview of the demand for WIC provision within Portsmouth City and an indication as to who utilises these services.

St Mary's Treatment Centre
There are currently circa 44,000 attendances at STMC WIC per annum; around 31,000 of these attendances are for patients registered with GP practices within Portsmouth, while around 13,000 attendances are for patients registered with GP practices outside of Portsmouth. Approximately 2/3 of the attendances are for minor injuries, whilst 1/3 are minor illness related.

Guildhall Walk Healthcare Centre
Excluding patients registered at GHWC, there are circa 20,000 attendances at GWHC WIC per annum; around 13,500 of these attendances are for patients registered with another GP practice within Portsmouth, while around 6,500 attendances are for patients registered with GP practices outside of Portsmouth. All of these attendances are for minor illnesses (as the GWHC WIC does not treat minor injuries). Approximately 45% of these occur during core GP hours (08:00-18:30, Monday-Friday).

4. Strategic Development of Urgent Care and Primary Care

This section looks at the strategic direction of urgent care services documented in the national Five Year Forward View and the CCG's 20/20 Vision strategy. Both documents will assist in shaping the commissioning decisions that need to be undertaken when constructing future healthcare provision in Portsmouth.

4.1. The NHS Five Year Forward View

The NHS Five Year Forward View (FYFV) was devised in 2014 in partnership between NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission, and the NHS Trust Development Authority. It articulates why change is needed in the NHS, what that change might look like, and how it might be achieved. In relation to urgent care services the FYFV offers a strategic vision of how they may be configured in the future and what the priorities are to help transition to this vision.

The FYFV highlights the need to dissolve the traditional boundaries currently segregating healthcare services, which can be categorised as: primary care, community services, and hospitals. The strategy emphasises the need for the care provided outside acute hospitals to

become a much larger part of what the NHS does. One example of this is the expansion of diagnostic services within community hospital settings to meet the urgent care needs of patients, as opposed to relying on patients increasingly visiting acute hospital settings. The importance of the need to expand and strengthen primary and 'out of hospital' care as means to managing urgent healthcare needs is highlighted throughout the FYFV. The emphasis of having community bases equipped to manage more diverse urgent care needs indicates that services commissioned locally will need to provide a much greater range of tests and treatments in one location without the need for healthcare professionals to refer patients on.

The FYFV emphasises the importance of continuing list-based primary care and ensuring its stability over the next five years. "General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS". The plan looks to expand scope of services provided in primary care and to encourage GPs to tackle health inequalities.

There is recognition that the traditional model of general practice is evolving. This is partly in response to national (and local) pressures that relate to the recruitment of GPs. In 2014 there were around 130 GPs working in the city, just over a fifth of whom were over the age of 55. A Local Medical Council (LMC) survey responded to by 48 of the GPs working in the city (less than half) showed that 40 per cent were thinking about retiring over the next five years – about 19 GPs. The emphasis is increasingly on extended group practices, either as federations, networks or single organisations, to enable a wider scope of services to be delivered. Meeting the demand on urgent care systems will be achieved either by ensuring evening and weekend access to GPs or having community bases equipped to provide a much greater range of tests and treatments.

4.2. Portsmouth CCG's 20/20 Vision

In 2014 Portsmouth CCG published its five year strategic plan, *20/20 Vision*. Within this document it is recognised that in order to meet the future health needs of people living within Portsmouth, and to do this on the funding predicted to be available, then a credible and robust plan would need to be in place detailing what changes would need to be enacted, and what key priorities would enable us to make those changes.

The key priority area within the *20/20 Vision* relevant to urgent care states: ***"We want everyone to be able to access the right health services, in the right place, as and when they need them."*** and a commitment to this ambition means that:

- People will know how and when to access the most appropriate services in an emergency
- People will not have to wait longer than they should for appointments, treatment and emergency care
- There will be an increase in the availability of x-rays, scans and tests so people can be diagnosed and receive the treatment they need more quickly

As a CCG we are signalling our intention to develop hub-based models of care in community settings incorporating primary care, community care, social care, and elements of secondary care. Decisions about the future of individual GP practices and groups of practices should be assessed in the light of this ambition and how it moves us closer to this goal

5. An Opportunity for Change

The current contract for the GWHC contract is due to expire at the end of March 2016 and this provides the CCG with a unique opportunity to review the current configuration of walk in

services within Portsmouth and to ensure that these commissioned services meet the needs of the population and deliver a more sustainable model of care for the future.

Based on the feedback from the various engagement exercises conducted with key stakeholders, the direction of travel in both national and local healthcare strategies, the CCG's preference would be to have all WIC activity delivered from one location within Portsmouth, at St Mary's Treatment Centre. The rationale for this includes the following:

- It will simplify and strengthen walk in services in the city by bringing together GP-led and nurse-led Walk-In services
- Patients and other health care providers will not have to choose between an injury or an illness service
- It will create a simpler overall structure for urgent care services which the public can navigate
- It place services where they can operate most effectively, to high standards, and remain accessible to those who need them
- It will improve access to x-rays, scans, and tests for those patients accessing walk in services as they will be co-located
- It will maximise the use of St Mary's campus, a strategic site in Portsmouth

The CCG is now consulting specifically on the proposal to relocate the GP led walk-in service from GHW to the St Marys treatment Centre.

6. Wider Implications: Guildhall Walk GP Practice for registered patients

The current GWHC contract binds the provision of WIC and primary medical care services together, therefore any decision about the future of WIC provision must be considered in the context of what impact it will have on the GWHC GP practice.

The GP practice located at GWHC has approximately 6,000 registered patients consisting mostly of students and young people; in fact, 15-34 year olds make up around 60% of the registered list, whereas patients aged over 75 account for only around 1%. In addition to the student and younger person dominated demographic, the practice also provides important access to primary care for the City's homeless population and other vulnerable patients.

The CCG is now consulting specifically on the impact and options for the GP services with those patients registered with the GHWC.

7. Engagement and Consultation

Over the previous 18 months the CCG has been working to consult with a wide range of stakeholders regarding the use of urgent care services with the City; this includes members of the public, patients, and providers of care. The timeline below summarises this activity with more detail provided in the pages that follow. This seeks to provide insight into how our engagement activity has unfolded over the past 18 months and how we are moving into some more detailed activity now that some firm proposals have been identified.

We remain very keen to remind people that the proposals around the walk in service focus on enabling them to make decisions about their care more easily and represent a relocation of the existing service with the retention of capacity, not the withdrawal of much needed alternative provision to urgent care services in Portsmouth. To ensure that we are able to seek the views of as many people as possible, from as many different backgrounds, we have also undertaken an Equality Impact Assessment on the proposals.

2013	**Discussions with GP commissioning leads and Patient Participation Group representatives**

2014	**JAN/FEB**	**MAY/JUNE**	**SUMMER**
	Under Pressure campaign and survey with The News	**Portsmouth University & Highbury student interviews**	**3 x CCGs urgent care survey**

2015	**JAN/FEB**	**APRIL**	**MAY/JUNE**	**JUNE 3rd**	**JUNE 4th**
	Urgent care campaign and survey with Wave 105fm	**Publication of engagement report**	**Meeting with GHW practice**	**Further discussions with GP commissioning leads**	**Letter & survey to all GHW patients**
	JUNE	**JUNE 16th**	**JUNE/JULY**	**JULY 1st**	**JULY 1st**
	Briefings to HOSP, HASC, local MPs, HWB, Healthwatch	**HOSP meeting**	**Develop plans for working with Salvation Army over impact on homeless contract**	**Launch of walk in survey to accompany registered patients survey**	**Meeting with PPG network (16)**
	JULY 2nd	**JULY 3rd**	**JULY 7th**	**JULY 9th**	**JULY 15th**
	Media & social media promotion of surveys for reg and walk in patients	**Specific contact with Carers Groups to identify impact**	**Social media reminder for students at Portsmouth University**	**Meeting with Healthwatch to discuss proposals**	**Update to CCG Governing Board**
	JULY 20th	**JULY 22nd**			
	Meeting with Portsmouth University	**Update meeting with HOSP**			

7.1. Engagement activity since June Health Overview and Scrutiny Panel

This section highlights engagement activity that we have undertaken since the HOSP meeting in June 2015.

Walk in services: we are now running a more detailed survey about the Guildhall Walk and St Mary's walk in centre arrangements to ascertain people's thoughts and concerns about our proposals. This is being done via an on line survey on the CCG's website and seeks to understand the issues that are important to the public and what concerns they would have regarding this proposal. The survey was made live on June 26th and promoted to the media. The link was made available on the CCG website, posted on the CCGs Urgent Care Facebook page and on the CCG twitter feed. The information on the website is accessible via a 'banner' on the homepage. The consultation will end on August 31st. Again this will continue to be promoted over the next few weeks and is running until the end of August. We are linking with a number of other organisations locally to seek their support in publicising the survey more fully.

Registered patients: In order to fully consider the impact on the practice population we are currently conducting survey-based engagement with the practice's 6,000 registered patients to understand how they use the service and the impact of any changes on them. Initially a letter and request to complete the online survey was sent to every patient's registered address on June 1st 2015 and the consultation will run until August 31st 2015.

This letter explained that the CCG has decisions to make over the next few months regarding the future of the practice and that broadly the options are:

- To continue to fund the same range of services at Guildhall Walk
- To move some of the services currently provided there to other locations, or to move the practice itself
- To end the contract for GP services there, and ensure that patients can register at other practices instead

Further work will be undertaken to continue to promote the survey between now and the end of August and we have had some help from the university in allowing us to utilise some of their engagement channels with students to remind them of the survey and request their support in filling it in.

As at 30th June 2015, there had been 162 responses to the survey, which was sent to all people registered as patients at Guildhall Walk Healthcare Centre. The initial mailing was supplemented by an online article in the 'student' section of the University of Portsmouth website, and subsequently by mentions on both Twitter and the Urgent Care Pompey Facebook page.

The survey has now been made available via the CCGs website and social media has been used to increase awareness of this ongoing consultation. The consultation will continue until the end of August 2015

Meetings and discussions: since the last HOSP meeting we have had a number of useful meetings and discussions with several different organisations and groups and we will continue to pursue these over the summer. These have included:

- A meeting with representatives of Healthwatch Portsmouth to identify possible areas for Healthwatch to be able to encourage people in the city to air their views. As well as supporting us with some publicity it may be that Healthwatch can also offer an

independent ‘take’ on the proposals and help us gain access to a broader range of groups and communities

- A meeting with representatives of the Patient Participation Groups in Portsmouth were we were able to explain our proposals to them and ask them to encourage patients in their surgeries to do the survey

- The practice provides primary medical services to a significant number of people who describe themselves as homeless; we will therefore be working with the Salvation Army to use semi-structured focus groups with the homeless population and potentially linking with Public Health colleagues who are planning a wider health needs assessment with this group. It is expected that this work will be completed by August 14th.

- The practice also supports a number of registered patients with drug and alcohol issues so we will be linking with relevant commissioners and user groups e.g. PUSH

- We are also working with the current provider to explore future options and whether the end of this contract provides an opportunity to explore more innovative solution and ways of delivering primary care.

- The University of Portsmouth has agreed to support us in contacting students through some of their social media channels and we are meeting with representatives from the University on July 20th to discuss the proposals in more detail

- We have also sought the support of both Adult Social Care colleagues and Action Portsmouth to disseminate information regarding both aspects of the current consultation via their networks.

Feedback, from these discussions is being collated and analysed, alongside the results from the survey and these will considered fully as we prepare our recommendations.

7.2. Urgent Care/Walk in: Engagement with service users

The activities outlined in section 7.1 help us to build on the findings of our initial round of engagement which took place between 2013 and early 2015 and featured three significant pieces of survey work focused on urgent care services, along with discussions with GPs and Patient Participation Group representatives. This initial engagement work helped us build a picture of behaviour, experience, perception and expectation in those who have, or may, use urgent care services in Portsmouth, Fareham, Gosport and South Eastern Hampshire through a range of public engagement and consultation activities.

The surveys were:

- Under Pressure survey: conducted with The News in January 2014 following our week long campaign with them seeking to raise awareness of local services. 414 people took part, 60% of whom were aged between 18 and 64
- Our own CCG urgent care survey: conducted during the summer of 2014. 808 people took part again 60% were aged between 18 and 64
- Wave 105 survey: conducted in February 2015 following a month long campaign that featured radio and video promotions featuring local providers of urgent care and their staff. 2637 people took part , 450 of whom were from the Portsmouth, South Eastern Hampshire area

Key Findings from these surveys:

The public are confused, don’t know enough about the options available to them and few, for example, know the differences between St Mary’s Treatment Centre and Guildhall Walk

walk-in service. Almost one-third of people don't know GPs offer same-day appointments. Many people would prefer a simpler system, even if this means fewer choices.

The most popular suggestion for easing pressure at A&E was "making it easier to see a GP" More personal responsibility/self care, more information, and simplicity are seen as key principles. GPs are the preferred, trusted option for minor illnesses, but for minor injuries people look to walk-in facilities. Proximity to services matters, however almost 60% of respondents think travelling up to 3-4 miles between home and a walk-in centre is reasonable.

The CCG has also been engaging with member practices via our commissioning events.

Key Findings from engagement with member practices

Member practices generally support ongoing provision of a minor injury walk in service at St Mary's but the stand alone nurse led minor illness services at St Mary's is generally not thought to be an effective way to manage demand and co-location with a GP led services is generally supported. GPs expressed some preference for having capacity to deal with their own patients in-hours BUT there were concerns over current capacity in-hours for GP services and meeting patient expectations. Practices therefore recognise the current ongoing need for a GP led walk in service in the City to manage demand until such times as primary care services can be remodelled.

8. Next steps

In order to inform the full development of the options outlined above the following work is in hand

- Continuation of consultation and engagement with the public and stakeholders
- Completion of an Equity Impact Assessment
- Review of current capacity in existing GP practices
- Assessment of financial impact of the options referred to above

We are working towards completing our engagement and consultation activity by Monday 31st August 2015 and we would anticipate that we would be presenting a preferred set of proposals to the CCG's Governing Board at its meeting on Wednesday 23rd September. We would be happy to update members of the Health Overview and Scrutiny Panel further on our progress at its meeting on Friday 18th September.

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ST. MARY'S TREATMENT CENTRE – Minor Injury & Ailment Unit

Agenda slide

1. About the unit
2. Staffing model
3. What we can treat /and not treat
4. Overview of service provided
5. See and Treat model of care
6. Summary

Introduction of the Unit

- The Minor Injury and Minor Ailment unit is a Nurse lead Service treating patients seven days a week, 365 days of the year
- Opening hours are: Monday to Friday from 7.30am until 10.00pm
- Weekends and Bank Holidays the unit is open from 8.00am until 10.00pm
- We see adults and children for both minor injuries and minor illness
- We are able to provide x-ray services for all hours of service where there is a need to identify a fractures of the limbs. We hold 2 Fracture clinics a week and a weekly review clinic
- The unit has a large adult waiting room, a designated children's waiting room and 11 consultation cubicles. Further provision of cubicles is planned
- We also have a Pharmacy store on site and are able to provide patients with required medications at the point of discharge. We can also provide the patient with a prescription if they require a specific medication that we do not hold on site.

Staffing model

- The Minor Injury and Minor Ailment Unit is Nurse Lead. This means that all the patients are seen , treated and discharged by highly experienced and qualified Nurse Practitioners
- The Team is lead by the Service Manager and Lead Nurse and supported by the Senior Management Team which consists of the Hospital Director and the Operations Manager. There is management cover for all hours of the service provided
- There is a designated Senior Nurse Practitioner who takes the role of Nurse in Charge for each shift
- Supporting the Senior Nurse Practitioners are the Associate Nurse Practitioners
- Health Care Assistants (HCAs) support all level nurses within the unit from dressing wounds to performing observations on the patients

What we can see and treat – Minor Injury and Minor Ailments

Examples of the service provided:

- Remove Sutures
- Suture and close wounds
- Remove foreign bodies from ears, noses etc
- Remove splinters
- Dress minor wounds, cuts and grazes
- Apply plaster of paris to fractured limbs
- X-ray arms and legs
- Provide emergency contraception
- Provide health care information
- Sprains and strains
- Broken bones to arms, leg and feet
- Wound infections
- Minor burns
- Minor head injuries
- Insect and animal bites
- Minor eye injuries
- Minor injuries to back and shoulder
- Sore throats
- Mild coughs
- Earache
- Minor rashes

What we are not able to see

If patients present with the symptoms below we will Assess and redirect the most appropriate way including 999 ambulance to Acute Trust

Chest Pain

Breathing difficulties

Major injuries

Severe Stomach Pains

Pregnancy related conditions / problems

Women's problems

Allergic reactions

Overdoses

Alcohol related problems

OR

CONDITIONS LIKELY TO REQUIRE HOSPITAL ADMISSION

Overview of service provided

- On average we see between 120-130 patients a day
- 99% of the patients are seen treated and discharged within the governments targets of 4 hours
- Over 90% of the patients attending the unit are assessed by a clinician within 30 minutes of arrival

See and Treat model of care

- See and Treat operates during the opening times of the unit
- It is run by a Senior Nurse Practitioner with advanced skills
- The system is designed to filter out patients who have very simple health needs (simple cut, cough, cold, sore throat) and are able to be seen, treated and discharged from the initial assessment stage within 10minutes.
- This system is ideal for working people as it is quick safe and effective and allows them to return to work

Summary

- The Minor Injury / Ailment unit is a fast and easy access to a clinician seven days a week 52 weeks a year making patient access easy
- Patients can be treated for either injury or ailment at the unit or both
- Pharmacy store on site and are we able to provide patients with any required medications at the point of discharge if stocked
- The facilities at St Mary's are maintained to a high standard with a designated children and separate adult waiting area with ample consulting rooms
- Adequate car parking onsite which is especially convenient to patients at the evenings and weekends as the car park is only used by the patients using this service
- The service greatly supports the Emergency Departments, Out of Hours service and local GP Practices in offering an alternative service

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Portsmouth Hospitals NHS
NHS Trust

Ursula Ward MSc MA
Chief Executive

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Chair, Health Overview & Scrutiny Panel
Customer, Community & Democratic Services
Portsmouth City Council
Civic Offices
Guildhall Square
Portsmouth
PO1 2AL

14 July 2015

Dear Chair

Update letter from Portsmouth Hospitals NHS Trust

I write to provide the Health Overview Scrutiny Panel with an update from Portsmouth Hospitals NHS Trust. I hope to attend the meeting, accompanied by Medical Director Mr Simon Holmes. Together we can provide further detail and explanation at the formal HOSP meeting on 22 July.

Members will be aware that the hospital trust was inspected by the Care Quality Commission (CQC) between 10 and 13 February 2015, with additional unannounced visits on 25 and 26 February and 2 March 2015. The full inspection team included CQC managers, inspectors and analysts, doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers.

The full set of reports from their inspection was published on 19 June, and the ratings given were:

Overall Rating:	Requires Improvement
Are the services safe?	Requires improvement
Are the services effective?	Good
Are the services caring?	Outstanding
Are the services responsive?	Requires improvement
Are the services well-led?	Requires improvement

We are delighted that the CQC has rated the overall care that our staff provides as Outstanding. This is a well-deserved testament to the hard work, dedication and

commitment of all of our staff. Within their report they recognise that the quality of the overall service provided within critical care is outstanding, whilst that in maternity and gynaecology; children and young people's services and outpatients are all rated as good.

In particular, our staff were recognised as providing person-centred care, as caring and compassionate and as treating patients with dignity and respect.

The overall rating of 'Requires Improvement' places us in the same category as other local NHS trusts including University Hospital Southampton NHS Foundation Trust, the Isle of Wight NHS Trust and Southern Health NHS Foundation Trust and along with 70% of other Trusts in the country who have been inspected by the CQC.

However, the CQC also identified some key areas of challenge. In particular, the CQC rated our A&E; medical care; surgery and end of life care services as 'requires improvement'. Whilst the hard work and commitment of our colleagues working in these areas is not in doubt, we do accept these findings and whilst disappointing, are not a surprise and we have already made significant changes to introduce improvements in these areas.

A detailed action plan is in place to further address those areas for improvement within the report and we will continue to work closely with our colleagues within the local healthcare system to effect the changes that will enable all of our services to provide our patients with the perfect care and experience that they deserve.

The full report can be found on the CQC website on this link: http://www.cqc.org.uk/provider/RHU

Our outcomes in the national staff survey had been very positive this year reflecting the passion and commitment of our staff:

- We had 3,728 responses, which is 54% of all of our staff responding. This places us in the top 20% of acute Trusts nationally.
- The responses received from staff showed a very positive shift in comments.
- We leapt to the top 20% in 10 key findings when compared to all acute Trusts nationally.
- Our Listening into Action work has made a real difference and the methodology has become embedded and importantly we have met our CQUIN target.

Our staff also continue to receive much national acclaim. I am proud that our Diabetes team were shortlisted in the BMJ Clinical Leadership Team of the Year Awards for their work called Diabetes care with STYLE (Safe Transition to Young adult Life).

Our Research and Innovation Team were also shortlisted for the BMJ Award for patient safety and their MISSION COPD project. MISSION is a quality improvement project that identifies patients with high-risk or undiagnosed chronic obstructive pulmonary disease (COPD) from GP practices, with rapid evaluation in primary care,

followed by comprehensive, specialist multi-disciplinary assessment in hospital. It will deliver interventions to NICE quality standards throughout the patient pathway.

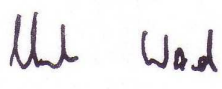
The team also celebrated a second huge success winning part of a new £1.5million innovation programme funding pot called Innovating for Improvement. This aims to improve health care delivery and/or the way people manage their own health care by testing and developing innovative ideas and approaches and putting them into practice. The selected projects will be led by clinical teams and will develop their innovative ideas and approaches, put them into practice and gather evidence about how their innovation improves quality. Each team will receive up to £75,000 of funding to support the implementation and measurement of their project. This is well-deserved recognition for our hard working team and firmly puts our research contribution on the national map.

We're also thrilled that we have been officially recognised as one of the best places to work in a prestigious NHS awards ceremony. The Best Places to Work 2015 Awards, which is run by the Health Service Journal, Nursing Times and NHS Employers, recognised the hospital trust among the top 40 Acute Trusts nationwide. We recognise that it is our people who make the difference to patients and it is no coincidence that one of the best places to work also received an outstanding rating from the CQC for the level of care provided through our services

Positive feedback from our patients is never taken for granted. I take great pride in sharing examples of well-earned feedback and praise for our staff across the organisation and each year we also share our examples of professionalism and pride in the annual staff awards. This provides the opportunity to nominate a member of staff, or a team, for the 'Patient's Choice' award, a new category within our annual Best People Awards. The 2015 Patient's Choice award is for members of the public to thank a Portsmouth Hospitals employee or team who have made a real difference to their, or a relative's, healthcare. We encourage on-line nominations on our website www.porthosp.nhs.uk.

Finally, save the date in your diaries as we have announced our annual hospital Open Day, which will be held on Saturday 3 October 2015. These have been hugely successful in the last few years and give our local population a great opportunity to see behind the scenes, tour departments and meet our lovely staff. We hope to see many of you there and the event will be widely advertised in the coming months.

Kind regards



Ursula Ward MSc MA
Chief Executive

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Portsmouth Hospitals NHS Trust

Quality Report

Queen Alexandra Hospital
Trust Headquarters
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Southwick Hill Road
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Tel: 023 9228 6000
Website: www.porthosp.nhs.uk

Date of inspection visit: 10 – 13 February 2015 and unannounced on 22 February and 2 March 2015
Date of publication: 19/06/2015

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Portsmouth Hospital NHS Trust provides a full range of elective and emergency medical and surgical services to a local community of approximately 675,000 people who live in Portsmouth city centre and the surrounding areas of South East Hampshire. It provides some tertiary services to a wider catchment of approximately two million people. The trust also provides specialist renal and transplantation services and is host to the largest of five Ministry of Defence Hospital Units in England. Ministry of Defence staff work alongside NHS staff in the trust but have a separate leadership command structure. The trust employs over 7,000 staff.

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. It is the amalgamation of three previous district general hospitals, re-commissioned into a Private Finance Initiative (PFI) in 2009. The hospital has approximately 1,250 inpatient beds, and has over 137,000 emergency attendances and over 429,000 outpatient attendances each year. There are 6,000 staff employed by the Trust and approximately a further 1,000 are employed by a provide provider in portering, cleaning, maintenance and catering services under a PFI arrangements. The trust has not yet applied for foundation status

The trust also provides outpatient services in community hospitals at Gosport War Memorial Hospital, Petersfield Community Hospital and St Mary's Hospital. Gosport War Memorial Hospital has a minor injuries unit, inpatient rehabilitation on Ark Royal Ward (16 beds) and the Blake Maternity Unit (six beds). Petersfield Community Hospital has inpatient rehabilitation on Cedar Ward (22 beds) and the Grange Maternity Unit (four beds). There are eight satellite renal dialysis services, with six across Hampshire, one in Salisbury (Wiltshire) and one in Bognor Regis (West Sussex).

We undertook this inspection of Portsmouth Hospital NHS Trust as part of our comprehensive inspection programme.

Services provided at Queen Alexandra Hospital include accident and emergency, medical care, surgery, critical care, maternity and gynaecological services, children and young people's services, end of life care, and outpatient and diagnostic services. These eight core services are always inspected by the Care Quality Commission (CQC) as part of its new approach to the comprehensive inspection of hospitals. The services provided in community hospitals are integrated into the trust clinical and management structures; we have incorporated these within the core service areas.

The inspection took place between 10 and 13 February 2015, with additional unannounced visits on 25 and 26 February and 2 March 2015. The full inspection team included CQC managers, inspectors and analysts, doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers.

Overall, we rated this trust as 'requires improvement'. We rated it 'outstanding' for providing caring services and 'good' for effective services, but the trust 'required improvement' for providing safe, responsive and well-led services.

We rated critical care services as 'outstanding'; maternity and gynaecology, and care of children and young people and outpatients and diagnostic imaging as 'good'; and urgent and emergency services, medical care, surgery and end of life care as 'requires improvement'.

Our key findings were as follows:

Is the trust well-led?

- The trust had a three year strategy that aimed to deliver high quality patient care, working in partnership and supporting innovation in healthcare. There was a focus on emergency care with plans to transform services to reduce admissions to hospital and deliver care closer to home. However, many of these priorities were underdeveloped and the trust was dealing with the immediacy of capacity issues. Clinical services did not have joined up strategies and did not work effectively to support the flow of patients through hospital.
- The leadership team was in the process of change and development. There was the commitment to improve and deliver excellent services, but there were gaps in operational performance and delivery, particularly around the unscheduled care pathway. The trust had worked with the wider health economy but did not have clear plans to deliver service improvements and

Summary of findings

had not effectively delivered consistent improvement. There was a wide variation in the quality and safety of services across the trust, although many services were good or outstanding some areas of performance failures were not appropriately recognised. There had not been a recent formal assessment of the board's performance.

- The trust had all the elements of an effective governance framework but these were not being used effectively. There was a comprehensive integrated performance report to benchmark quality, operational, financial and workforce information and each clinical service centre had a quality dashboard. However, some risks were not identified and the action taken on known risks did not always mitigate these and were not always timely. Some risks had been on risk registers for several years without a clear resolution of the mitigating actions or a monitoring statement for risks that cannot be fully mitigated.
- We served two warning notices for the trust failure to respond to patient safety issues, and the failure to effectively assess and manage the risks to patients in the emergency department.
- Staff were positive about working for the trust and the quality of care they provided. The trust was similar to other trusts for staff engagement, but its staff survey had demonstrated year on year improvement. The trust 'Listening into Action' programme had demonstrated changes and improvements to services based on staff innovations. The staff had a strong sense of identify that was focused on care.
- There was a focus on improving patient experience and public engagement was developing. Safety Information was displayed in ward and clinic areas for patients and the public to see.
- The trust had a culture of innovation and research and staff were encouraged to participate. The trust had won a national award for clinical impact research. The award recognised the trust "Research in Residence Model" and its ability to harness clinical research to improve services and treatments for its patients.
- Cost improvement programmes were identified but savings were not being delivered as planned and the trust was having to take further action to reduce the risks of financial deficit.

Are services safe?

- Patients who arrived by ambulance at the emergency department (ED) were at risk of unsafe care and treatment. We served two warning notices to the trust requiring immediate improvement to be made to the initial assessment of patients, the safe delivery of care and treatment, and the management of emergency care in the ED.
- Patients were sometimes assessed according to the time that they arrived in the ED and not according to clinical need. Some patients with serious conditions waited over an hour to be clinically assessed, which meant that their condition was at risk of deteriorating. Many patients waited in corridors and in temporary bay areas. Patient in these areas and in the majors queue area were not adequately observed or monitored.
- The trust had introduced an initial clinical assessment by a healthcare assistant to mitigate risks, but this was not in line with national clinical guidelines.
- The environment in the ED did not enhance patient safety. The ED had been extended and its majors treatment area and children's treatment area were now a considerable distance from the resuscitation room. Staff had to negotiate crowded public areas in order to gain access to the resuscitation room. Patients were in areas, some temporary, where there was no access to essential equipment or call bells, and there was no safe area to support patients with a mental health condition.
- Nurse staffing levels were regularly reviewed using an appropriate and recognised management tool. There were high vacancy levels across the hospital, notably in the ED, the medical elderly care wards and the surgical assessment unit, where staffing levels were not always met and there were insufficient staff for the number of patients and the complexity of their care and treatment needs. Staffing levels were reviewed on a shift-by-shift basis and according to individual nursing requirements. Staff were transferred across units on a shift basis to try to reduce risk, but this affected the availability of expertise and continuity of care in other areas. There was high use of internal bank and agency staff, particularly on night shifts. Agency staff received an induction and safety briefing on wards before beginning their shift.
- Midwifery staff ratio was an average of 1:29 which was in line with the England average. The maternity dashboard clinical scorecard showed that the ratio

had varied from 1:27 to 1:33 over the past 10 months. This reflected the actual number of midwives to birth and did not include maternity support workers The recommendations of the Royal College of Obstetricians and Gynaecologists' guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) that there should be an average midwife to birth ratio of 1:28. Midwives, however, were working flexibly and one to one care was being provided for women in labour and with additional staff or strategies were provided to ensure the safety of antenatal and postoperative care.

- The trust had higher numbers than the England average of consultant medical staff in post, although it was not meeting national recommendations for consultant presence in maternity and for consultant staffing in end of life care. The trust had fewer middle-grade doctors and junior doctors compared with the England average and their workload was high in some specialties. For example, surgery and consultants in the ED were being stretched in an unsustainable way to cover posts and ensure safe services.
- Medical patients who were in the ED overnight and those on non-medical wards (outliers) were not always reviewed by specialist doctors in a timely way.
- Most services had a culture of openness and transparency. Staff understood the principles of duty of candour, and information, guidance and training were available to support staff to understand and implement the requirement of being open when things go wrong.
- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, venous thromboembolism (blood clots), catheter-related urinary tract infections and falls. The information was monitored throughout the hospital and the results were displayed for the public in clinical areas. The prevalence of catheter-related urinary tract infections was consistently low but the incidence of pressure ulcers and falls had not reduced but was increasing. Some pressure ulcer incidents were deemed unavoidable. However, the trust had not met its own targets for reduction in pressure ulcers and falls. There was evidence of actions taken in response but this varied; for example, the falls care bundle was used on medical wards but this was not used consistently on surgical wards.
- Staff were reporting incidents and lessons were learnt and practice was changed as a result. On one surgical ward, however, staff were concerned that disciplinary action could be instigated unfairly for pressure ulcer incidents. The trust had said that staff may face disciplinary action if they failed to care for patients appropriately, but not if it was beyond their control. Recent hospital data, however, indicated a decrease in the reporting of pressure ulcers on this ward.
- The wards were visibly clean, and infection control practices were followed. The trust infection rates for MRSA and Clostridium difficile were within an expected range and the trust had not had a norovirus outbreak for five years. However, infection control arrangements in the surgical high care unit did not meet professional guidelines.
- Items of necessary equipment such as pressure-relieving mattresses, blood pressure monitors and medication pumps were not always readily available for patients when required. This meant that patient care and treatment could be delayed or adversely affected. The cardiac arrest call bell system in the E level theatres did not identify the location in which an emergency took place.
- Medicines were stored safely. However, the staff on a unit designated as an escalation ward told us they sometimes ran out of essential medications and had to borrow them from another ward. As a result there were delays in the timely administration
- Patients whose condition might deteriorate were being identified through the use of the early warning score. The trust had an electronic monitoring system for patients and this was used effectively, for example for the critical care outreach team to prioritise patients. However, early warning scores were not being used as part of bed management allocations.
- Staff were not always aware of standardised protocols or agreed indicators for pre-assessment to support them in making decisions about the appropriateness of patients for day case surgery
- Safeguarding processes to protect vulnerable adults, and children and young people were embedded across the hospital. There was a recent safeguarding policy and procedure, staff had attended appropriate training, and there was a culture of appropriate reporting.

Summary of findings

- Staff were undertaking mandatory training and progress towards trust targets was good for many staff disciplines with the exception of medical staff where attendance rates were low.
- The completion of patient records varied in some areas it was very good and in some places information could be missing, and it was not clear if this was part of the electronic or paper record. New end of life care plans were being piloted in response to the national withdrawal of the Liverpool Care Pathway. However, where these care plans were not used, the documentation, of care was not appropriate to properly assess and make decisions about patient care and treatment. Do not attempt cardiopulmonary resuscitation forms were not always appropriately completed.

Are services effective?

- Services provided care and treatment in line with national best practice guidelines, and outcomes for patients were often better than average or improving. However, operating procedures in theatres needed updating and end of life care guidance needed to be further developed across the trust. The trust needed to improve the management of stroke patients and it was not meeting the target for 90% of stroke patients to be cared for in a stroke unit.
- There was good participation in national and local audit programmes, although the trust did not fully participate in the National Care of the Dying Audit – Hospitals 2013/14.
- Patient outcomes, as measured by national audits, were either better than or similar to the England average; where they were below the average they were improving. Each clinical service centre had a quality dashboard to monitor patient safety outcomes although these needed further development to focus on clinical outcomes.
- The trust's mortality rates were within the expected range.
- Patients received good pain relief, in particular after surgery, in critical care and in end of life care. There were some delays, however, for patients who had arrived by ambulance in the ED.
- Patients, particularly older patients, were supported to ensure their hydration and nutrition needs were met. Although there were areas of concern identified on ward E3 for all patients and in end of life care on the acute medical unit.
- Staff were supported to access training and there was evidence of staff appraisal, although clinical supervision for nursing staff was under developed.
- Staff worked in multidisciplinary teams to centre care around patients. Physiotherapists on medical wards told us that although they did see medical patients, they could not always provide sufficient therapy sessions for their individual requirements.
- Discharge summaries giving GPs information on patient care were delayed. The trust was not meeting Department of Health standards for letters to be sent within 48 hours and there could be delays of up to two weeks. Renal outpatient letters were taking 35 days to be typed and sent to the patients' GP because the renal department had a separate IT system from the rest of the trust. This had caused significant delay in GPs receiving updated information regarding their patients' treatment.
- Seven-day consultant-led services were developed in all areas, with the exception of outpatient services. Support services such as imaging, pharmacy, physiotherapy and occupational therapy were also available seven days a week.
- Staff had appropriate knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that patients' best interests were protected. Guidance was available for staff to follow on the action they should take if they considered that a person lacked mental capacity. Notification of Deprivation of Liberty Safeguards applications were correctly submitted to the Commission.
- Critical care services demonstrated outstanding innovations in delivery of effective care, ensuring there were robust systems to deliver and monitor care to high standards by highly skilled staff.

Are services caring?

- The trust had a culture of compassionate care. Staff were caring and compassionate, and treated patients with dignity and respect. Many patients and relatives

told us that although staff were very busy, they were supported with compassion, patience, dignity and respect, with time being given to the delivery of personalised care.
- Staff were responsive to patients' emotional care needs. Emotional care was also provided by the chaplaincy department and patients and relatives told us show much they valued this service, which had supported them at difficult times.
- We observed outstanding care and compassion in critical care, maternity and gynaecology and children and young people's services. Staff were person-centred and supportive, and worked to ensure that patients and their relatives were actively involved in their care.
- Data from the NHS Friends and Family Test demonstrated that patients were satisfied with the care they received. Overall results were above the England average and the trust was in the top quarter of all trusts. Results were clearly displayed in ward areas.
- Patients' experiences of care was variable, however. There were concerns, particularly for patients on the surgical ward E3 where staff were busy and essential and timely personal care was not delivered and patient dignity and confidentiality was not always maintained. Some patients with end of life care needs on wards E3 and the acute medical unit did not always get the timely care the families thought necessary or appropriate, and care was sometimes given by relatives instead.

Are services responsive?

- The trust was not meeting national targets for the timely handover of patients from ambulances. The trust had not met the emergency access target for 95% of patients to be admitted, discharged or transferred from A&E within four hours since November 2013. There was no hospital-wide escalation response to overcrowding in the ED to improve flow in the hospital.
- Specialty teams were often delayed in seeing patients who had been in the ED overnight.
- Bed occupancy across the hospital was 92% (January 2014 to March 2015). This was consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Patients were not always admitted to wards according to their clinical needs and were being placed where beds became available. This meant that the necessary level of specialist expertise and experience may not always have been available to them.
- Patients could be moved several times during their admission. This happened at night and for non-clinical reasons. The trust identified that older patients, patients with high dependency and acuity needs and end of life care patients should not be moved. However, older patients, including patients who were confused, or living with dementia and who may have had complex conditions, were being moved.
- Patient moves were tracked but the information was not used effectively at ward level. Some medical staff told us they did not always know where to find them and this could lead to a delay in treatment. Patients' relatives also told us that they had difficulty finding patients.
- The critical care unit experienced discharge delays out of hours and delays to admission because of pressure on beds in the hospital. The unit had taken action to mitigate risks and this included comprehensive discharge summaries and a retrieval team who care for patients on the ward while they waited for admission.
- The national referral to treatment time target for 90% of patients to have surgery within 18 weeks was not met overall, although this was a planned fail in agreement with commissioners to address patients on the waiting list. Targets were not achieved in general surgery, trauma and orthopaedics, urology and ENT. In relation to urology, the trust attributed delays to limited staffing capacity, which had led to the cancellation of over 200 elective surgeries and a reduction in the number of elective patients admitted.
- Capacity issues within the hospital resulted in elective procedures being cancelled. Some patients told us their operations had been cancelled several times; although the majority did go on to have their surgery within 28 days.
- The trust was meeting the cancer waiting time target for 93% of patients to have referral from a GP to see a specialist within two weeks. The trust was also meeting the target for 96% of patients to have diagnosis to definitive treatment within one month (31 days). The trust had also met the target for 85% of

patients to be waiting less than two months (62 days) from referral to start of treatment from April 2014 to December 2014. However, the target had not been met in January 2015 to March 2015.

- The trust was meeting referral-to-treatment time targets for most outpatient specialities but there were long waiting times for patients attending colorectal clinics, back pain clinics and the gastroenterology clinic. There was evidence of action being taken to address the long waits.
- Patient had timely follow up outpatient appointments although there were patients waiting beyond their due date in colorectal surgery, orthopaedic and gastro specialities. Ophthalmology had a high number of patients with significant delays to follow-up and who were on an outpatients waiting list. This had been on the service risk register since 2009, but as a result of a serious incident requiring investigation that occurred as a result of this backlog, it was escalated to the trust risk register In April 2013. The waiting list had been reduced but the number of patients waiting was still significant
- The trust was now meeting the diagnostic waiting time target after extending the service times.
- Discharge plans were expected to commence on admission but this varied across wards, as did planning around simple and complex discharges. There were some delays in discharging patients and patients told us they had to wait a considerable time (hours) for their medications to take home. A discharge lounge was available and was used appropriately. Patients were able to have food and drink while waiting for discharge.
- The trust had delayed transfers of care and national data showed the main causes of delayed transfers of care at this trust (which could prevent a patient from being discharged) included waiting for nursing home places, waiting for social care arrangements, and patient/family choice. The trust was working with its partners to alleviate this problem and data published by NHS England (December 2014 to January 2015) demonstrated that the trust had a comparatively smaller number of delayed discharges compared with other similar trusts.
- The integrated model which the trust maternity service runs (Nurture programme) allowed flexible use of staff to maintain 1:1 care in labour. This had kept women's denied choice of place of birth to a minimum.
- There was a rapid access discharge service within 24 hours and the number of patients discharged to their preferred place and who were able to die at home was higher than the national average.
- In most clinical areas there was adequate provision to protect a patient's privacy and dignity. However, this was not the case for ambulance patients waiting in corridors in the emergency department and also for patients in the dialysis unit on the Isle of Wight. Patients attending for outpatient appointments had to walk through the dialysis unit where patients were receiving treatment in their beds to attend their consultations. In ophthalmology department at Queen Alexandra Hospital, patients receiving treatment (pupil dilation) were being treated in a room that was glass walled, enabling any person walking by to observe a patient being treated.
- Staff across the hospital demonstrated a good understanding of how to make reasonable adjustments for patients with a learning disability. However, care for patients living with dementia varied. Training, assessment, the use of the dementia care bundle and making reasonable adjustments to reduce stress and anxiety, we being used but not consistently. In some areas the care needs of people living with dementia were not always met. Some areas demonstrated excellent examples of the care such the 'memory lane' service on the elderly care wards. This was held once a week and included engaging patients in remembering their past times by means of music, games, reading material and communication.
- An interpreting service was available for people whose first language was not English and the service was used. All information for patients was only available in English. In radiology, easy-to-read leaflets were available for patients with a learning disability, where language style had been adjusted and pictures used to explain procedures. We did not see any other information in an easy-to-read format.
- Information from complaints was reviewed and acted on; although some patients told us they were not always given information about how to make a complaint.

Are services well-led?

- Many staff were committed to the values of the trust: 'best hospital, best people, best care'.

Summary of findings

- Most services did not have a formal written strategy, although aspects of future plans could be verbalised by staff. Staff in the ED were not aware or confident that there were clear plans and strategies to address significant concerns in a timely way.
- Departmental strategies and vision were generally well understood, except in medicine where no discernible long-term strategy could be described by staff.
- Clinical governance arrangements were well developed to assess and manage the quality of service provision. However, better management of risks was needed. Not all risks were appropriately identified, escalated and mitigated across service areas. The pressures in the ED were long-term and significant risks to patients had not been appropriately managed.
- Many staff told us overall they had good support from the local clinical leaders, for example ward managers and consultant staff. However, there were concerns, including: the support from managers at senior levels, the capacity of managers in the ED, of some ward managers and the fragmentation of management in end of life care.
- Many staff commented on the visible and approachable presence of the chief executive officer.
- Staff were positive and proud to work for the trust; many staff had worked in the trust for their entire career. There was an open and honest culture and a strong sense of teamwork across most areas. However, there were a few areas of concern and these were identified as the lack of hospital support and clinical engagement for the pressures in ED, the lack of integrated working across clinical service centres, the concern by staff on one ward of being unfairly disciplined for pressure ulcer incidents in surgery and the dysfunction team working in the colorectal team.
- There were innovative approaches to patient and public engagement across services, which included survey, focus groups, consultation, committee representation and the use of social media.
- Staff engagement was good, and the latest staff survey showed significant improvement in key areas. The trust was in the top 20% of trusts for staff engagement. The Listening in Action programme was cited as a particular example of involving staff in improving the quality of their services.
- There was a strong and visible commitment to research and development.
- Innovative ideas and approaches to care were encouraged and supported, and the trust was the recipient of many awards, both national and international, for the excellence of some of its services.
- The leadership in the critical care unit was outstanding.

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We saw many areas of outstanding practice including:

- A 'Coffee and conversation' group was held for patients in the stroke wards. This gave patients an opportunity to share their experiences, provide peer support and education. Patients were also given information about support available in the community.
- There were good arrangements for meeting the needs of patients with a learning disability, particularly in theatres. The staff showed good awareness of the specialist support that patients with complex needs sometimes require. Staff used a specialist pain management tool for assessing pain levels in patients who could not verbally communicate their experiences of pain.
- The trust had developed bespoke safeguarding training modules to meet the specific needs of staff and their working environments. For example, there was safeguarding training specific to the issues identified for staff working in theatres and specific types of wards.
- The practice of daily safety briefings on the intensive care unit (ICU) ensured the whole multidisciplinary team was aware of potential risks to patients and the running of the unit.
- In the ICU there were innovative approaches to the development and use of IT systems and social media. Secure Facebook and Twitter accounts enabled staff to be updated about events affecting the running of the service. This included information about risks, potential risks and incidents. Electronic 'Watch out' screens in the unit displayed information about incidents and the unit's risk register. The education team advertised information about training opportunities on the education Twitter account.
- In the ICU, innovative electronic recording systems supported the effective assessment and monitoring of patients.

Summary of findings

- The electronic monitoring system used in the hospital for monitoring patients' vital signs enabled staff to review patient information in real time and the outreach team to monitor patients on all wards and prioritise which patients they needed to attend to. This early warning system was developed in response to delayed care in deteriorating patients. Its adoption has saved over 400 deaths, and overall has reduced our mortality levels by 15%.
- Innovative and practical planning of emergency trolleys meant that all equipment needed to manage a patient's airway, including equipment to manage difficult airways and surgical equipment, was stored in a logical order and was immediately accessible.
- In most critical care services, beds are positioned to face into the ward. On some units beds were positioned so that conscious patients could look out of the window. Queen Alexandra Hospital's critical care unit had learnt that some patients were frightened when they could not see the ward and wanted to be able to see into the unit for reassurance. In response, the unit had equipment that could position beds at an angle so patients could see out of window as well as into the unit.
- In response to difficulties in recruiting middle-grade (registrar) doctors, the ICU in partnership with the University of Portsmouth was developing a two-year course in Advanced Critical Care Practice (ACCP). The planned outcome from this course was that Advanced Critical Care Practitioners would be employed in the unit to fulfil some of the medical tasks and release medical staff to do more complicated work. This was the first initiative of this kind in the UK.
- To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the ICU had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care team in the ED, before admission to the unit. The same practice was followed for patients requiring admission to the unit from the general wards.
- The innovative use of grab packs meant staff had instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.
- The critical care unit had developed their own innovative website that included educational information and guidance documents. There was guidance, tutorials and podcasts from recognised intensive care organisations, Portsmouth intensive care staff and other intensive care staff about the use of intensive care equipment and procedures. This was accessible to staff, staff from other trusts and the general public.
- A perineal clinic had been designed and implemented to provide outpatients care and treatment to women who had sustained third- and fourth-degree tears following delivery. This service enabled women to access treatment sooner than under previous systems. Staff also provided treatment, support, information and education to women who had experienced female genital mutilation.
- There was a telephone scheme for women who had experienced complex or traumatic deliveries to talk about, and have a debrief conversation, with a midwife following their discharge. The outcomes from the conversations were used as part of the governance processes and this had demonstrated a reduction in the number of complaints.
- A mobile telephone application (app) had been developed by the trust and the Chair of the Midwife Liaison Committee together with women who used the services. The app provided information on choices of place of birth and was being developed to include additional information. The app won an award from NHS England in the excellence in people category and the service had also been recognised with an innovation award from Portsmouth Hospitals NHS Trust.
- The multidisciplinary team in the children's and young people's services had made a commitment to creating an open culture of learning, reflection and improvement. This included listening to and empowering and involving staff, children, young people and their families. We found all staff, at all levels, were involved in working towards this goal and this was having a positive impact on improving the safety and quality of services for children, young people and their families.
- There was a new initiative called a 'talent panel', which was a mechanism to discover and develop staff, both for individual career development and the future

sustainability of the service. Staff of all grades were encouraged to submit their career aspirations to a panel so that steps to support them could be identified.
- The trust had introduced a volunteer programme for people who wanted to work as a chaplain's assistant. Volunteers were trained on how to support patients through visiting them. Through this training programme, the trust had over 50 volunteers coming to help and support patients.
- The trust received a national award for clinical research impact. The award recognised the trust "Research in Residence Model" and its ability to harness clinical research to improve services and treatments for its patients. The trust identified the development of the early warning system, mobile application for pregnant mothers (cited above), and developing methodologies to reduced respiratory exacerbations and admissions and detect upper and lower gastrointestinal cancer more effectively.

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

Importantly, the trust **must** ensure that:

- Patients are appropriately assessed and monitored in the ED to ensure they receive appropriate care and treatment.
- Ambulance patients are received and triaged in the ED by a qualified healthcare professional.
- There are effective system to identify, assess and manage the risks in the ED.
- There is an adequate supply of basic equipment and timely provision of pressure-relieving mattresses.
- The cardiac arrest call bell system in E level theatres is able to identify the location of the emergency.
- Medication is prescribed appropriately in surgery and is administered as prescribed in gynaecology
- The emergency resuscitation trolley on the gynaecology ward is appropriately checked.
- Appropriate standards of care are maintained on ward E3 and the acute medical unit.
- There is a hospital wide approach to address patient flow and patient care pathways across clinical service centres.
- Patients' bed moves are appropriately monitored and there is guidance around the frequency and timeliness of bed moves so that patients are not moved late at night, several times and for non-clinical reasons.
- Patients are allocated to specialist wards, when clinical need requires this, and medical outliers are regularly reviewed by medical consultants.
- Nurse staffing levels comply with safer staffing levels guidance.
- There are adequate numbers of medical staff on shifts at all times.
- All wards have the required skill mix to ensure patients are adequately supported by competent staff.
- The falls action plans are followed in a consistent way across the medical services.
- There is compliance with the WHO Surgical Safety Checklist.
- Staff awareness of standard protocols or agreed indicators for pre-assessment improves to support them in making decisions about the appropriateness of patients for day case surgery.
- Staff on all wards are able to raise concerns above ward level, particularly when this impacts on patient care, and there is a response to these concerns.
- Discharge summaries are sent out in a timely manner and include all relevant information in line with Department of Health (2009) guidelines.
- Staff observe recognised professional hand hygiene standards at all times.
- The surgical high care unit is risk-assessed for infection control risks.
- Medical and dental staff complete mandatory and statutory training.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Nursing handovers provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met.
- Nursing staff are appropriately trained in the safe use of syringe drivers.
- All pharmacists have an appropriate understanding of insulin sliding scales and where such information should be recorded.
- Patient confidentiality is protected so that patients and visitors cannot overhear confidential discussions about patients' care and treatment.
- Records are kept relating to the assessment and monitoring of deteriorating patients in recovery.

Summary of findings

- Patient records and drug charts are complete and contain all required information relating to a patient's care and treatment.
- Do not attempt cardiopulmonary resuscitation forms are completed appropriately and mental capacity assessments, where relevant, are always performed.
- Patient records are stored so that confidentiality is maintained.
- The trust fully participates in all national audits for which it is eligible on end of life care.
- Action is taken to improve the leadership where there are services and ward areas of concern.

At a trust level:

- The trust clinical strategy is supported by clear improvement plans and these are monitored and evaluated appropriately.
- Governance arrangements are managed effectively so that there is appropriate assurance around risk and performance.
- The trust board has a development programme and there should be appropriate and timely assessment of its performance.
- There is continued investment in PALS.
- Complaints are appropriately monitored and responded to in a timely manner.

In addition, the trust has a number of actions that it should take and these are identified in the location report for Queen Alexandra Hospital.

Professor Sir Mike Richards, Chief Inspector of Hospitals

Summary of findings

Background to Portsmouth Hospitals NHS Trust

Portsmouth Hospital NHS Trust provides a full range of elective and emergency medical and surgical services to a local community of approximately 675,000 people who live in Portsmouth city centre and the surrounding areas of South East Hampshire. It provides some tertiary services to a wider catchment of approximately two million people. The trust also provides specialist renal and transplantation services and is host to the largest of five Ministry of Defence Hospital Units in England. The trust employs over 7,000 staff.

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. It is the amalgamation of three previous district general hospitals, re-commissioned into a Private Finance Initiative (PFI) in 2009. The hospital has approximately 1,250 inpatient beds, and has over 137,000 emergency attendances and over 429,000 outpatient attendances each year. The hospital employs more than 6,000 staff. Staff working in portering, cleaning, maintenance and catering services are employed by a private provider under PFI arrangements. The trust has not yet applied for foundation status.

The trust also provides outpatient services in community hospitals at Gosport War Memorial Hospital, Petersfield Community Hospital and St. Mary's Hospital. Gosport War Memorial Hospital has a minor injuries unit, inpatient rehabilitation on Ark Royal Ward (16 beds) and the Blake Maternity Unit (six beds). Petersfield Community Hospital has inpatient rehabilitation on Cedar Ward (22 beds) and the Grange Maternity Unit (four beds). There are eight satellite renal dialysis services, with six across Hampshire, one in Salisbury (Wiltshire) and one in Bognor Regis (West Sussex).

Services provided at Queen Alexandra Hospital include accident and emergency, medical care, surgery, critical care, maternity and gynaecological services, children and young people's services, end of life care, and outpatient and diagnostic services. These eight core services are always inspected by the Care Quality Commission (CQC) as part of its new approach to the comprehensive inspection of hospitals. The services provided in community hospitals are integrated into the trust clinical and management structures; we have incorporated these within the core service areas.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector for Hospitals, Care Quality Commission.

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission.

The team of 56 included CQC managers, inspectors and analysts, and a variety of specialists including: consultant in emergency medicine; consultant gynaecologist and obstetrician; consultant surgeon; consultant anaesthetist; consultant physicians; consultant geriatricians; consultant radiologist; consultant oncologist; consultant paediatrician; junior doctor; emergency department matron; midwife; gynaecology nurse; surgical nurses; theatre nurse; medical nurses; paediatric nurses, neonatal nurse specialist, optometrist; palliative care specialist nurse; critical care nurses; outpatient manager, board-level clinicians; governance lead; safeguarding leads; a student nurse; and experts by experience.

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider: Is it safe? Is it effective? Is it caring? Is it responsive to people's needs? Is it well-led?

We carried out an announced inspection visit from 10 to 13 February 2015. We completed the inspection through unannounced and out-of-hours inspections to services on 25 and 26 February and 2 March 2015.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups; Monitor; Health Education England; General Medical Council; Nursing and Midwifery Council; Royal College of Nursing; NHS Litigation Authority; and the local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Portsmouth on 10 February 2015 when people shared their views and experiences of the Portsmouth Hospitals NHS Trust.

We conducted focus groups and spoke with a range of staff in the hospital, including nurses, matrons, junior doctors, consultants, administrative and clerical staff, porters, maintenance, catering, domestic, allied healthcare professionals and pharmacists. We also interviewed directorate and service managers and the trust senior management team.

During our inspection we spoke with patients and staff from all areas of the hospital, including the wards and the outpatient department. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

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

What people who use the trust's services say

- We held a public listening event, on 9 February 2015. The event was attended by 110 people. Overall people were positive about the trust but identified some areas for improvement.

There were positive comments on the following:

- The hospital was friendly and had a strong sense of identity
- Consultants staff were caring, approachable and took time to listen
- Staff were caring in the Emergency Department
- Good cancer care and good care from the renal teams
- Good care in vascular and orthopaedic surgery and nursing staff on the surgical admissions unit were good
- Excellent care in the critical care unit and high dependency unit.
- Good experience of maternity services overall
- Outpatient services were good - Hearing Aid service, Fracture Liaison Service Rheumatology service. Telephone reminders for outpatient appointments were helpful.

There were negative comments on the following:

- Nurse staffing at night - nurses were understaffed and dismissive to patients
- Nurse handover was incorrect and nursing staff were defensive with information was corrected
- Too few nursing staff for the hospital
- Medical outliers received inappropriate care
- Multiple moves of elderly patients between wards
- IT systems not fit for purpose and nurses had too much paperwork
- Infection control practices needed to improve
- Electronic consent meant patients did not receive a copy
- Poor liaison with social services for discharge

Summary of findings

- The Patient Advice and Liaison Service (PALS) was not well advertised
- Long waiting times in the ED on a trolley with no privacy
- Many people with alcohol and drug problems in the ED
- Unsatisfactory discharge from the medical assessment unit
- Physiotherapists mobilised patients with fractured hops too early
- Poor dementia care and families not informed;
- Patients on the Liverpool Care Pathway and families not informed.
- Long waiting time in outpatients for hearing aids and for X-ray
- Detail in outpatient letters insufficient and too complex.
- Missing medical records on multiple occasions in outpatients.

- The results of the NHS Friends and Family Test (FFT) January - July 2014 showed that the trust scored above the England average overall for inpatient wards. The A&E scores showed that the trust was above the England average. Recent scores up to December 2014 showed that trust had a net score that was in the top 20% of trusts.
- The CQC adult inpatient survey (2013): The trust had performed similar to other trusts in the six areas of question on the hospital and ward, nurses, doctors, care and treatment, operations and procedures and leaving hospital.
- The CQC A&E survey (2014): The trust performed similar to other trusts for all questions. The questions covered
- The Cancer Patient Experience Survey (CPES) by the Department of Health 2013/14 is designed to monitor national progress on cancer care. Of 34 questions, the trust performed similar to other trusts overall. The trust was worse than other trusts (in the bottom 20% of trusts) for two questions: patient's GP given enough information about their condition and treatment and patients never thought they were given conflicting information. The trust was better than other trust (in the top 20% of trust) for two questions: Staff told patients who to contact following discharge and patients saw their GP once or twice before being told they were going into hospital.
- The CQC Survey of Women's Experiences of Birth 2014 showed that the trust was performing about the same as other trusts on all questions on care, treatment and information during labour, birth and care after birth.
- Patient-led assessment of the care environment (PLACE) were self-assessments undertaken by teams of NHS and independent healthcare staff, and also by the public and patients. They focused on the environment. In 2014, the trust scored higher than the national average for cleanliness (99%, compared to 98% nationally), privacy, dignity and well-being (92%, compared to 87%), and facilities (96%, compared to 92%). However food and hydration was below the national average (97%, compared to 90%).

Facts and data about this trust

Portsmouth Hospitals NHS Trust: Key facts and figures

PHT has five registered locations: The Queen Alexandra Hospital, Gosport War Memorial Hospital, St Mary's Community Campus, Fareham Community Hospital, Petersfield Community Hospital, St and eight Renal Dialysis Units across Hampshire and the Isle of Wight.

The majority of the Trust's acute services are now provided at Queen Alexandra Hospital following the completion of recent redevelopment.

1. Context:

- Queen Alexandra Hospital has around 1,255 beds.
- Gosport War Memorial Hospital - Ark Royal Ward (16 beds) and Blake Maternity Unit (6 beds)
- Petersfield Community Hospital (Cedar Ward) (22 beds).
- The local population is around 550,000.
- The number of staff is around 7,000.
- The board has 0% Black and ethnic minority members representation of executive directors and 0% Black and ethnic minority members representation of non-executive directors; it has 33.3% female representation of executive directors and 20% female representation of non-executive directors.

Summary of findings

- Deprivation in the City of Portsmouth is higher than average (76 out of 362 local authorities). The surrounding areas of Gosport, Fareham and East Hampshire are less deprived.
- Life expectancy for both men and women is worse than the England average.
- The trusts income for 2013/14 was £469,147,000; the costs were £468,317,000.
- The trust surplus was £830,000 (2013/14).

2. Activity:

- Inpatient admissions: 96,146 (2013/14).
- Outpatient attendances: 463,515 (11/2013 to 10/2014).
- A&E attendances: 137,864 (11/2013 to 10/2014).
- Births: 5,966 (July 2013 to June 2014) 98.5% single births and 1.5% multiple births.
- Deaths: 805 (April 2013 to March 2014).

3. Bed occupancy:

- General and acute: 92.2% (April 2014 to June 2014). This was consistently above both the England average of 88% and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Maternity was at 71% bed occupancy (April 2014 to June 2014) and consistently higher than the England average of 57.9%.
- Adult critical care was at 82.4% bed occupancy – below the England average of 87.6% in January 2015.
- Level three neonatal intensive care unit.

4. Intelligent Monitoring:

Priority banding for inspection*

Oct 13 - 4 (4.3%)

Mar 14 - 6 (0.5%)

Jul 14 - 6 (2.1%)

Dec 14 - 6 (3.2%)

*For each acute trust we have published an intelligence monitoring report. We have also placed each trust into a priority band from one (highest perceived concern) to six (lowest perceived concern). While the bands will help us to decide which trusts we may inspect first, they don't represent a judgement or a ranking of care quality

Individual risks/elevated risks:

- Elevated risk: Composite indicator, A&E waiting times more than four hours (July 2014 to September 2014).
- Elevated risk: Diagnostic waiting times: Patients waiting over six weeks for a diagnostic test (July 2014).
- Risk: Sentinel Stroke National Audit Programme Domain 2: Overall team-centred rating score for key stroke unit indicator (April 2014 to June 2014).
- Risk: TDA Escalation score (June 2014).

5. Safe:

- 'Never events' in past year: 3 (2013/14).
- Serious incidents: 116 (2013/14) – 63% were pressure ulcers.
- National Reporting and Learning System April 2013 to May 2014; no evidence of risk.

Acute

Death - 7 (0.1%)

Severe harm - 101 (1.3%)

Moderate harm - 138 (1.8%)

Low harm - 2,405 (30.5%)

No harm - 5,212 (66.3%)

Total 7,863

Infection control (March 2013 to September 2014)

- 53 cases of Clostridium difficile – no evidence of risk.
- Three cases of MRSA – incidence – no evidence of risk.

Waiting times – Safe Domain

- A&E – time to initial assessment: above (from January 2014) the England average and 15 minute standard (January 2013 to October 2014).
- A&E – time to treatment: similar to the England average, and standard time of 60 minutes (January 2013 to October 2014).

6. Effective:

(December 2014)

- Hospital Standardised Mortality Ratio: no evidence of risk (Intelligent Monitoring).
- Summary Hospital-level Mortality Indicator: no evidence of risk (Intelligent Monitoring).

7. Caring:

- CQC Inpatient Survey (10 areas): similar to other trusts.

Summary of findings

- Friends and Family Test inpatient: 96% above the England average 94% (January 2015).
- Friends and Family Test A&E: 95% above the England average 88% (January 2015).
- Cancer Patient Experience Survey (34 questions): similar to other trusts for 30 questions; lowest scoring 20% of trusts for two questions and highest scoring 20% for two questions.

8. Responsive:

- A&E four-hour standard – not met; below the England average and 95% target (April 2013 to December 2014).
- Emergency admissions waiting 4–12 hours in A&E from decision to admit to admission: above the England average.
- A&E left without being seen: above the England average (December 2013 to September 2014).
- 18-week referral-to-treatment – surgery (admitted adjusted) – similar to 90% NHS operating standard (April 2013 to June 2014).
- 18-week referral-to-treatment (non-admitted and incomplete pathways – outpatient) – above 95% NHS operating standard (April 2013 to June 2014).
- Cancelled operations and not treated within 28 days – above the England average in June 2014.
- Cancer waiting times: Better than or similar to England average for urgent two weeks (seen by specialist), 31 days (diagnosis to treatment) and 62 days (urgent referral to treatment).
- Diagnostic waiting times – Although flagged as an Elevated Risk by Intelligent Monitoring, waiting times had dropped below the England average by October 2014.

9. Well-led:

- NHS Staff survey 2013 (30 questions): Better than expected (in top 20% of trusts) for two questions; worse than expected for seven questions; similar to expected for 21 questions.
- Use of bank and agency staff – below the England average.
- Sickness rate – below the England average.
- General Medical Council National Training Scheme Survey (2013): The trust was within expectations for all areas of the National Training Scheme Survey.

10. CQC Inspection History:

- Eight inspections had taken place at the trust since August 2011. All inspections have been at Queen Alexandra Hospital.
- The trust was non-compliant with Outcome 9, Medicines management and Outcome 4, Care and welfare of people who use services in October 2011, and later was non-compliant for Outcome 21, Records in March 2012. All three outcomes have been re-inspected and the trust found compliant.

Summary of findings

Our judgements about each of our five key questions

Rating

Are services at this trust safe?

Requires improvement

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

Overall we rated the safety of the services at the trust as 'requires improvement'. For specific information, please refer to the individual reports for Queen Alexandra Hospital.

The team made eight separate judgements about the safety of services in the trust and there was a variation in judgements. One was judged as 'inadequate', three as 'requiring improvement', three as 'good' and one as 'outstanding'. This meant that the trust did not consistently protect people from avoidable harm and also that learning to share good practice was not effective.

The trust had patient safety priorities identified for 2014/15. These covered the development of a safety culture, reducing avoidable harms such as pressure ulcers, infections and falls, general ward safety (for example, identifying the deteriorating patient, Sepsis and acute kidney injury care) and improving the care of frail elderly and reducing medication errors. In December 2014, the trust had identified overall positive progress with the plan but there were areas where progress had not developed as plan. The trust was still in the bottom 20% of trusts for reporting incidents to the National Reporting and Learning System (NRLS) on time. Avoidable harms such as pressure ulcers and falls had not reduced by 10% according to trust plans and c.difficile infections were within an expected range but were higher than local targets.

Critical care services demonstrated outstanding and innovative safety procedures to protect patients from avoidable harm.

Assessing responding to risks

- Patients who arrived by ambulance at the emergency department (ED) were at risk of unsafe care and treatment. We served two warning notices to the trust requiring immediate improvement to be made to the initial assessment of patients, the safe delivery of care and treatment, and the management of emergency care in the ED.
- Patients were sometimes assessed according to the time that they arrived in the ED and not according to clinical need. Some patients with serious conditions waited over an hour to be clinically assessed, which meant that their condition was at risk of deteriorating. Many patients waited in corridors and in

temporary bay areas. Patient in these areas and in the majors queue area were not adequately observed or monitored. The trust had introduced an initial clinical assessment by a healthcare assistant to mitigate risks, but this was not in line with national clinical guidelines.

- Patients whose condition might deteriorate were being identified through the use of the early warning score. The trust had an electronic monitoring system for patients and this was used effectively, for example for the critical care outreach team to prioritise patients. However, early warning scores were not being used as part of bed management allocations and we found patient with higher acuity and dependency needs being moved several times.
- The trust had introduced the “Nerve Centre” to coordinate the Hospital at Night team. This had improved the escalation of patients at risk and bed management and had reduced the number of incidents. The model of the Nerve Centre, however, did not run during the day time and bed management was run by the clinical service centres. This had caused a number of delays when identifying beds.

Duty of Candour

- The trust Duty of Candour and Being Open Policy was developed in January 2014 and advised staff to be open, transparent and candid with patients when things go wrong. The policy had been updated in January 2015, to take account of the Duty of Candour regulation which came into effect in the NHS on 27 November 2014. The policy introduced procedures and guidance for the trust to meet the requirements of the Duty of Candour.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- The principles of candour were generally well embedded in the organisation. Most services had a culture of openness and transparency even if the ‘duty of candour’ was not part of the safety vocabulary of the trust. Staff understood the principles of duty of candour, and information, guidance and training were available to support staff to understand and implement the requirement of being open when things go wrong. Senior staff

could describe their responsibilities around duty of candour and all staff consistently told us that the trust supported them to be open and transparent about the need to identify mistakes, accept responsibility and apologise.

Safeguarding

- Safeguarding was overseen by the trust safeguarding committee. The trust safeguarding lead was the director of nursing and each clinical service centre had an adult safeguarding operational lead. There was a safeguarding children's team and a safeguarding children's group as a subcommittee of the trust safeguarding committee. The trust committee and children's group were monitoring the implementation of trust policies for the safeguarding of adults and children, and staff training.
- The trust was working with partners to ensure an area wide approach to safeguarding issues, particularly as the majority (75%) were related to issues about community care services, which were recognised on admission to the hospital or disclosed to staff during the patients stay. The majority of internal safeguarding alerts were for pressure ulcers and 11% were related to allegations of abuse, neglect or omissions of care. Actions as a result of safeguarding incidents were implemented and monitored. The trust annual report included reference to the implementation of new guidance and policies, for example, prevent strategies (prevention of terrorism).
- Safeguarding training for adults and children was well attending and trust targets (85% attendance) were met. Staff were aware of the relevant policies for safeguarding vulnerable adults and children and knew how to access them. Staff could describe situations in which they would raise a safeguarding concern and could describe the action they would take. There was an appropriate reporting culture.

Incidents

- Staff told us how they were encouraged to report incidents, near misses and errors and that they received feedback and learning was shared within clinical teams and service centres. There was less evidence of learning being shared across the trust.
- The trust had reported 7,863 incidents to the NRLS from April 2013 to May 2014. This was lower than expected rate of NRLS incidents. The majority (97%) of these incidents were low risk or no harm incidents. Moderate incident accounted for 2% of all incidents and serious incidents (severe harm or death) 1%.

- The majority of serious incidents had been for pressure ulcers (grade 3 and 4) and venous thromboembolism. The trust had reported three Never Events in 2014, two for wrong site surgery and one drug error. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. These incidents had been investigated through root cause analysis and the learning implemented.
- We reviewed three SIRIs and found these to be well structured, with appropriate conclusions and recommendations with specific responsibilities and timescale for actions identified. There were prompts to share wider learning across the trust, but these were not always used effectively.

Staffing

- Nurse staffing levels were regularly reviewed using an appropriate and recognised management tool. There were high vacancy levels across the hospital, notably in the ED, the medical elderly care wards and the surgical assessment unit, where safe staffing levels were not always met. There were insufficient staff for the number of patients and the complexity of their care and treatment needs. Staffing levels were reviewed on a shift-by-shift basis and according to individual nursing requirements. Staff were transferred across units on a shift basis to try to reduce risk, but this affected the availability of expertise and continuity of care in other areas. There was high use of internal bank and agency staff, particularly on night shifts. Agency staff received an induction and safety briefing on wards before beginning their shift.
- The trust had higher numbers than the England average of consultant medical staff in post, although it was not meeting national recommendations for consultant presence in maternity and for consultant staffing in end of life care. The trust had fewer middle-grade doctors and junior doctors compared with the England average and their workload was high in some specialties, for example, in surgery and the ED. Consultants in the ED were being stretched in an unsustainable way to cover vacant middle grade posts and ensure safe services.
- Midwifery staff ratio was an average of 1:29 which was in line with the England average. The maternity dashboard clinical scorecard showed that the ratio had varied from 1:27 to 1:33 over the past 10 months. This reflected the actual number of midwives to birth and did not include maternity support workers The recommendations of the Royal College of Obstetricians and Gynaecologists' guidance (Safer Childbirth:

Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) that there should be an average midwife to birth ratio of 1:28. Midwives, however, were working flexibly and one to one care was being provided for women in labour and with additional staff or strategies were provided to ensure the safety of antenatal and postoperative care.

Are services at this trust effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Overall we rated the effectiveness of the services at the trust as 'good'. For specific information, please refer to the individual report for Queen Alexandra Hospital.

The team made eight separate judgements about the effectiveness of services. One in end of life care was judged as 'requires improvement', six were judged as 'good', and one in critical care was judged as 'outstanding'.

Although there were some variations, this meant, overall, that patients received effective care and treatment that met their needs. National evidence-based guidelines and best practice was used to guide the treatment of patient, and clinical audit was used to monitor standards of care. Patient outcomes were good and mortality rates were within the expected range.

Patients had good pain relief although there were some delays for patients who had arrived by ambulance. Patients received appropriate nutrition and hydration although there were some concerns on ward E3 and on the acute medical unit. Staff worked in multidisciplinary teams to co-ordinate care around the patient and were supported with training and encouraged to develop their skills. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal guidelines. Seven day services were developed in many areas, including for emergency care, with the exception of outpatient services.

There was some evidence of working with community teams but overall these needed to be further developed. GP discharge summaries were delayed which did not support seamless care.

Evidence-based care and treatment

- Staff used national guidelines, for example, from NICE, and relevant Royal Colleges to determine care and treatment in local pathways, care bundles and procedures. In most areas there was adherence to guidance and policies, although we

identified some variations, for example operating procedures in theatres needed updating and end of life care guidance needed to be further developed across the trust. The trust needed to improve the management of stroke patients and it was not meeting the target for 90% of stroke patients to be cared for in a stroke unit.
- The trust formally reviewed all NICE guidance to agree its use and to monitor implementation across services.

Patient outcomes

- The trust participated in national audits although it had not fully participated in the National Care of the Dying Audit – Hospitals 2013/14. The trust identified to us that this had been a mistake. Standards were monitored through local clinical audit programmes. Although these could vary, each clinical service centre had a clinical audit programme and annual clinical audit report and improvements to services could be demonstrated as a result.
- Patient outcomes, as measured by national audits, were either better than England average, and or similar; where they were below the average they were improving. Each clinical service centre had a quality dashboard to monitor patient safety outcomes although these needed further development to focus on outcomes of clinical effectiveness.
- The hospital could demonstrate outcomes that were significantly better than the national average in critical care, neonatal care, colorectal surgery, cardiac surgery, orthopaedic surgery, diabetes care, rheumatology, ophthalmology, for breast and gastric cancers.
- Mortality rates in the trust was within expected range. The introduction of electronic monitoring had reduced mortality.

Multidisciplinary working

- There was good multidisciplinary team working. Staff liaised effectively on the wards to coordinate patient care and some ward rounds were conducted by multi-disciplinary teams. Patients had been referred to specialists when required, for example, speech and language therapy or for dietetic advice. However, multi-disciplinary working needed to improve in places, for example physiotherapy for medical patients and in the care of stroke patients.
- Services were also being coordinated outside the trust. For examples, GPs could refer directly to the midwifery service and,

there were effective networks for intensive care, integrated working for diabetes care, and the community children's team from Solent NHS Trust supported early discharge of children with complex needs
- Discharge summaries giving GPs information on patient care were delayed across the trust. There could be delays of up to two weeks, and even longer, instead of within 48 hours. This did not promote seamless care into the community.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust had a consent policy which included details about when patients lacked capacity and where to obtain more specialist information. However, we did not have evidence that this was the subject of regular audit.
- Staff followed appropriate consent procedures. We found consent forms had been completed appropriately and included details about the procedure/operation and any possible risks or side effects were completed. Staff also demonstrated an awareness of their responsibilities under the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLs) to ensure patients best interest were protected. We found, where patients lacked capacity mental capacity assessments were done although this was not demonstrated on do not attempt cardiopulmonary resuscitation forms.

Are services at this trust caring?

Outstanding ☆

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

Overall we rated the caring provided by staff at the trust as 'outstanding'. For specific information, please refer to the individual report for Queen Alexandra Hospital.

The team made eight separate judgements about the caring. One was judged as 'requires improvement' Four were judged as 'good' and three, in critical care, maternity and gynaecology and children and young people's services were judged as 'outstanding'.

This meant, overall that feedback from patients was continually positive. Patients, their families and carers told us about how staff were 'excellent, kind and helpful' and many ward areas could demonstrate the plaudits they had received. The trust had a culture of compassionate care. Staff were highly motivated to provide compassion care that promoted people's dignity. Many services had a strong visible person-centred approach with individual patient preferences and needs reflected in how care was delivered.

Summary of findings

Patients, their relatives or carers were involved in their care and in some places, active partners, with staff empowering patients to have a voice in their care. Patient's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Compassionate care

- The trust had an initiative in place called 'back to basics', which required staff to introduce themselves by name to patients with the understanding that this was the first step of compassionate care. We observed staff introducing themselves to patients by their preferred name.
- Staff were caring and compassionate, and treated patients with dignity and respect. Many patients and relatives told us that although staff were very busy, they were supported with compassion, patience, dignity and respect, with time being given to the delivery of personalised care. Staff were responsive to patient needs and answered call bells promptly, although this varied in a few areas. Staff in the outpatient departments were approachable, reassuring and professional.
- We observed outstanding care and compassion in critical care, maternity and gynaecology and children and young people's services. Staff were person-centred and supportive, and worked to ensure that patients and their relatives were actively involved in their care.
- Data from the NHS Friends and Family Test demonstrated that patients were satisfied with the care they received. Overall results were above the England average and the trust was in the top quarter of all trusts. Results were clearly displayed in ward areas.
- The CQC Survey of Women's Experiences of Maternity Services 2013 and also responses to the Friends and Family Tests showed the trust to be performing about the same as other trusts in maternity care.
- The cancer patient experience survey (2013/14) was similar to other trusts overall.
- Patients' experiences of care was variable, however. There were concerns, particularly for patients on the surgical ward E3 where staff were busy, and essential and timely personal care was not delivered and patient dignity and confidentiality was not always maintained. Some patients with end of life care needs on wards E3 and the acute medical unit did not always get the timely care the families thought necessary or appropriate, and care was sometimes given by relatives instead.

Summary of findings

Understanding and involvement of patients and those close to them

- Patients and their relatives told us they were involved in decisions about their care and treatment. They told us their care and treatment options had been explained to them at all times and they had sufficient opportunity to speak with consultant staff.
- In medical services, patients on the stroke unit were involved in developing their care plan, and understood what was in place for the future management of their stroke. The therapy and nursing staff on the stroke wards arranged family meetings with patients' relatives within two weeks of patients' admission. These meetings involved discussions around patients' progress, goals and their involvement in care. The relatives we spoke with commented positively about these meetings and found them a very useful source of information.
- In critical care, patients, where possible and relatives told us they felt fully informed about care and treatment and this was discussed in a manner they could understand. Staff communicated sensitively, and provided explanations about the equipment and what was happening to reduce any anxiety. Records of conversations were detailed on the electronic recording system. This meant staff always knew what explanations had been provided and reduced the risk of confusing or conflicting information being given to relatives and patients.
- In maternity services, women described the excellent care and support, particularly if they had complex needs. They were complimentary about the detailed information provided by midwives and how this had ensured they understood the care they required without being made to worry about their condition. Women were involved in handover discussions between staff to keep them involved and informed about their care.
- In children and young people 's services, staff spent time talking to parents and also to the children and young adults so that they could all understand, in way that was meaningful and reassuring to them, what was happening during their stay. Play leaders spent time with children to support them to understand their care. Children with long term conditions or who were long stay patients had diaries to record key information and they and their parents could write questions and comments, and receive a response.
- The families of patients receiving end of life care told us they were informed about the condition of their relative and had time to speak with doctors and they did not feel rushed. They

told us that staff were good at communicating and had, for example, discussed death or dying in a comforting manner. Relatives told us they were encouraged to get involved in the care of patients. For example, they were encouraged to provide mouth care for end of life care patients.

Emotional support

- Staff across the trust demonstrated a good understanding of patient's and relatives emotional needs. Emotional care was also provided by the chaplaincy department and patients and relatives told us much they valued this service. A multi-faith chapel was available for people of all faiths to support their spiritual needs.
- In the emergency department, staff gave open and honest answers to questions and provided as much reassurance as possible. Support was particularly strong for relatives of patients who needed to be in the resuscitation room. We observed nurses preparing relatives before they entered the resuscitation room and then carefully explaining what had happened and the details of the immediate treatment plan.
- The intensive care unit offered follow-up clinics where patients were invited to return so their stay and care in the ICU could be explained to them to aid them with their emotional recovery. Feedback from these clinics had resulted in changes to care practices to reduce anxieties experienced by patients after discharge from the unit. This included asking patients about their experiences of hallucinations while they were a patient in the ICU, assessing what actions/noises in the unit could be contributing to causing the hallucinations and trying to eliminate some of those noises and actions.
- Follow up telephone calls were offered to women who may have had a difficult or complex birth and specific assessment and support for women who may have lost their babies during pregnancy. There was also follow up telephone calls for women who had had gynaecological procedures and support groups for women with conditions such as ovarian cancer or endometriosis. There were specialist midwife, for example in bereavement to support women.
- In the children's and young people's services, play workers provided advocacy for children and emotional support. Peer support and social groups were actively promoted with parents and children, in the neonatal intensive care unit. Parents and carers could accompany children to the anaesthetic room and

stay with them until they were asleep, and were with their child in theatre recovery when they were awake. Families were able to stay close to their children by their bedside during their hospital stay.

- Psychological support was also available. For example, stroke patients had a mood assessment pathway and had appropriate clinical psychological referral and psychology services were available for children and young people living with long-term conditions and receiving specialist services Clinical nurse specialists offered support for specific conditions.

Are services at this trust responsive?
By responsive, we mean that services are organised so that they meet people's needs.

Requires improvement

Overall we rated the responsiveness of the services at the trust as 'requires improvement'. For specific information, please refer to the individual report Queen Alexandra Hospital.

The team made eight separate judgements on whether services were responsive. Four were judged as 'requires improvement', four in critical care, maternity and gynaecology, end of life care and outpatient and diagnostic imaging services were judged as 'good'. This meant that the trust was delivering responsive services but not consistently and there were areas where standards were not met.

The trust understood the needs of its local population and was planning service change in response to the increasing demand for services. However, the trust had not effectively tackled its most urgent problem, that of increasing number of emergency admissions and patient flow through the hospital. Operation plans were reactive and focused within the emergency department and there was not an improvement plans that focused on hospital wide solutions. The hospitals environment was modern although some areas, unaffected by the private finance initiative, refurbishment and redesign.

Patient's privacy and dignity was respected but there were areas where this needed to improve in the emergency department, the dialysis unit on the Isle of Wight and in the ophthalmology outpatient area.

There was good support for people with a learning disability and for people living with dementia, although dementia care varied across the trust.

Summary of findings

Patients were not always aware of how to make a complaint and there needed to be better investment in Patient Advice and Liaison Services (PALS) to support patients to raise concerns and issues informally. Complaints were handled appropriately but could take some time to complete.

Service planning and delivery to meet the needs of local people

- The trust understood the needs of the local population and was planning for service change. The socio-economic profile and demographics of the surrounding areas had been analysed and the trust understood the challenge of an ageing population with multiple comorbidities which at present was representing a significant emergency admission problem. The trust had strategic plans to work with partners around integrated pathways of care, particularly for the frail elderly, but these were currently underdeveloped.
- The current challenge of emergency admissions was considered “complex” and somewhat of an inevitability. Crucially there was strategic and operational inertia in planning and responses were focused on managing the immediate and constant service pressures. Some operational changes had occurred, for example, the majors area extension, but these were not well planned and were focused within the emergency department rather than hospital wide solution.
- The trust The trust was identifying some improvement initiatives but did not have a finalised improvement plan for the emergency care pathway at the time of our inspection, and did not have an appropriate escalation plan to ensure patient safety and improve the flow of patients through the hospital, when there was overcrowding - a frequent occurrence - in the emergency department. Its most significant pressure was not being managed appropriately.
- Some services were using information to understand the needs of the local population and services were changing in response to increasing demand, for example, ambulatory care, a GP nurse and nurse practitioners in the surgical assessment unit, and increases in the number of intensive care beds.
- The hospital was newly built in 2009, and many service areas had modern environments and facilities. Some areas (the emergency department and older parts of the hospital that had not been under the private finance initiative) required refurbishment and redesign to improve patient flow and the patient experience.

Meeting people's individual needs

- Staff across the hospital demonstrated a good understanding of how to make reasonable adjustments for patients with a learning disability. We observed that reasonable adjustments were being made, for example, the use of communication booklet s in children' services and to reduce anxiety and provide support for patients having surgery. There was a specialist learning disability nurse and good use of the care passport scheme (a document used by patients with a learning disability to outline their care needs and preferences and information about them for staff to reference). However, the trust did not have an effective system to flag patient with a learning disability who may be admitted or who might attend an outpatient clinic.
- The trust had adopted policies and procedures designed to identify and promote the support of people living with dementia. For example all patients over 75 years were screened on admission using recognised methodology, the 'this is me' booklet was being used to recognise the people's preferences and needs there was a dementia care bundle to provide appropriate support. However, care for patients living with dementia varied, as well as training, assessment, the use of the dementia care bundle and making reasonable adjustments to reduce stress and anxiety. The care needs of people living with dementia were not always met. A recognised symbol was not used to identify people and encourage additional support and the care needs were not always met. The trust did not have a specialist dementia nurse but there was a lead nurse and dementia champions on the wards. Some areas did demonstrate excellent examples of the care such the 'memory lane' service on the elderly care wards. This was held once a week and included engaging patients in remembering their past times by means of music, games, reading material and communication.
- There was an arrangement with the local NHS mental health trust to provide a liaison service for people with a learning disability and mental health disorders. The mental health team worked in the emergency department and inpatient areas. The trust had a mental health specialist midwife and a consultant trained in perinatal mental health problems. The trust however, could not always access specialist support for patients with drug and alcohol problems.
- In most clinical areas there was adequate provision to protect a patient's privacy and dignity. However, this was not the case for ambulance patients waiting in corridors in the emergency department and also for patients in the dialysis unit on the Isle

of Wight. Patients attending for outpatient appointments had to walk through the dialysis unit where patients were receiving treatment in their beds to attend their consultations. In ophthalmology department at Queen Alexandra Hospital, patients receiving treatment (pupil dilation) were being treated in a room that was glass walled, enabling any person walking by to observe a patient being treated.

- An interpreting service was available for people whose first language was not English and the service was used. All information for patients was only available in English. In radiology, easy-to-read leaflets were available for patients with a learning disability, where language style had been adjusted and pictures used to explain procedures. We did not see any other information in an easy-to-read format

Access and flow

- Bed occupancy at the trust was 92% (January 2014 -March 2015), consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.. Adult critical care was at 82.4% bed occupancy – below the England average of 83.2%.
- The trust had described an increasing number of emergency admissions and significant and enduring pressures on the emergency care pathway. The impact of this was being felt throughout the trust. Ambulances were waiting longer to admit patients and “queueing” ambulances were a problem at times. Though infrequent, some patients were held in a large ambulance (called a “Jumbulance”) outside of the emergency department (ED) which was a completely inappropriate environment for sick patients. Patients were not being assessed and treated within standard times in the emergency department and the trust was not meeting the emergency access target for 95% patients to be admitted, transferred or discharged within four hours. This target had not been met since November 2013.
- Patient flow throughout the hospital was a significant concern and patients had lengthy waits for an inpatient bed and, at times of peak demand, many waited on a trolley in the corridor. The trust had a significant number of patients that breached 12 hour waits and patients were waiting in the ED up to and over 14 hours. The ED did not always prioritise patients for beds based on their clinical needs.

Summary of findings

- Many inpatients, particularly medical patients were not on specialists wards and during the inspection, there were 59 medical outliers (patients placed on wards other than one required by their medical condition). These patients were not always regularly reviewed by medical consultants.
- Patients could be moved several times during their admission. This happened at night and for non-clinical reasons. The trust identified that older patients, patients with high dependency and acuity needs and end of life care patients should not be moved. However, older patients, including patients who were confused, or living with dementia and who may have had complex conditions, were being moved.
- The critical care unit experienced discharge delays out of hours and delays to admission because of pressure on beds in the hospital. There were a higher number of patients discharged overnight than in similar units. The Core Standards for Intensive care 2013 detail that historically discharges from critical care services overnight have been associated with excess mortality and a poor patient experience. The unit had taken action to mitigate risks and this included comprehensive discharge summaries and a retrieval team who care for patients on the ward while they waited for admission.
- The trust was not meeting the referral-to-treatment time targets for 90% of patients to start treatment within 18 weeks of referral. Because of high demand for emergency surgery, elective procedures were increasingly being cancelled. Some patients told us their operations had been cancelled several times, although the majority did go on to have their surgery within 28 days.
- The trust was meeting the cancer waiting time targets overall. The target for referral to treatment within two months had not been met in January 2015. Most patients had timely outpatient follow up appointments but some patients, in colorectal surgery, orthopaedic and gastroenterology and ophthalmology specialties had longer waiting times. The ophthalmology waiting time had been identified as a serious risk for the trust and action was being taken.
- Patients experienced discharge delays on their expected day of admission, for example, waiting for medication but the trust had worked effectively with partners to reduce the number of discharge delays for patients waiting for nursing home places, waiting for social care arrangements, and patient/family choice.

Data published by NHS England (December 2014 to January 2015) demonstrated that the trust had a comparatively smaller number of delayed discharges compared with other similar trusts.

- There was a rapid access discharge service within 24 hours and the number of patients discharged to their preferred place and who were able to die at home was higher than the national average.

Learning from complaints and concerns

- During 2013/14 the trust handled a total of 691 complaints. This was an increase by 30% compared to the previous year. The top five themes were similar to the NHS and these were clinical treatment (including delayed diagnosis), delayed admission, transfer or discharge, staff attitude, appointment delays or cancellations and communication. All but two complaints were acknowledged within the Department of Health 3 working days expected timeframe.
- Over the same time period, the trust had had a corresponding decrease in the number of contacts to the Patient Liaison and Advisory Service (PALS). Patients told us that PALS were not visible and this was increasing formal action rather than trusting local discussions and informal resolutions. The trust was reviewing, and reinvesting, in the work of PALS in an effort to cultivate a more proactive approach to concerns by undertaking the following: reinstating the drop-in office within the main reception area allowing an opportunity to have problems resolved on the spot; ensuring there is a PALS officer available during core hours to offer advice and support; providing better signage for the PALS area within main reception; PALS regularly visiting our inpatient areas and speaking with patients and relatives.
- The trust did not have an overall timeframe to respond to complaints to ensure consistent and prompt responses. The trust also did not record the number of days to complete a complaint. Data reviewed from 1 April 2014 to 30 November 2014 demonstrated that complaints were taking on average between 2 to 3 months to complete. The trust was not monitoring open and overdue complaint cases to improve the timeliness of response. The trust, had only introduced the monitoring of complaint outcomes (ie whether they were upheld or not) in April 2014. The findings were that 65% were upheld and the trust now required each clinical service centre to devise and implement and improvement plan.

Summary of findings

- We reviewed three recent complaints. These complaints were responded to according to guidelines and there were adequate details and clarity on the lessons learnt.
- During 2013/14 the Parliamentary and Health Service Ombudsman (PHSO) had 14 complaint contacts from the trust. This was only a slight increase from the previous year (which was 13). One case was under review but 10 cases were not upheld and only three were upheld or partially upheld. This meant that most complaints were being effectively resolved through the trusts' complaints handling process.
- Information from complaints was reviewed and acted on; although some patients told us they were not always given information about how to make a complaint.
- The trust had plans to survey complainants, produced new information leaflets, develop staff training and improve data recording. This was being done to take action on the lessons learnt from complaints, for example around staff attitude and in order to improve access to complaints services and improve how complaints were handled.

Are services at this trust well-led?

Requires improvement

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as 'requires improvement'.

The trust had a three year strategy that aimed to deliver high quality patient care, working in partnership and supporting innovation in healthcare. There was a focus on emergency care with plans to transform services to reduce admissions to hospital and deliver care closer to home. However, many of these priorities were underdeveloped and the trust was dealing with the immediacy of capacity issues. Clinical services did not have joined up strategies and did not work effectively to support the flow of patients through hospital.

The leadership team was in the process of change and development. There was the commitment to improve and deliver excellent services, but there were gaps in operational performance and delivery, particularly around the unscheduled care pathway. The trust had worked with the wider health economy but did not have clear plans to deliver service improvements and had not effectively delivered consistent improvement. There was a wide

variation in the quality and safety of services across the trust, although many services were good or outstanding some areas of performance failures were not appropriately recognised. There had not been a recent formal assessment of the board's performance.

The trust had all the elements of an effective governance framework but these were not being used effectively. There was a comprehensive integrated performance report to benchmark quality, operational, financial and workforce information and each clinical service centre had a quality dashboard. However, some risks were not identified and the action taken on known risks did not always mitigate these and were not always timely. Some risks had been on risk registers for several years without a clear resolution of the mitigating actions or a monitoring statement for risks that cannot be fully mitigated.

We served two warning notices for the trust failure to respond to patient safety issues, and the failure to effectively assess and manage the risks to patients in the emergency department.

Staff were positive about working for the trust and the quality of care they provided. The trust was similar to other trusts for staff engagement, but its staff survey had demonstrated year on year improvement. The trust 'Listening into Action' programme had demonstrated changes and improvements to services based on staff innovations. The staff had a strong sense of identify that was focused on care.

There was a focus on improving patient experience and public engagement was developing. Safety Information was displayed in ward and clinic areas for patients and the public to see.

The trust had a culture of innovation and research and staff were encouraged to participate.

Cost improvement programmes were identified but savings were not being delivered as planned and the trust was having to take further action to reduce the risks of financial deficit. .

Vision and strategy

- The trust clinical strategy 2012/13 to 105/16 was reviewed in March 2014. The strategy identified the vision of the trust "To be recognised as a world-class hospital, leading the field through innovative healthcare solutions focused on the best outcome for our patients delivered in a safe, caring and inspiring environment".
- The aim of the strategy was to meet the needs of the population served and to transform services with a particular focus on unscheduled care, care of the frail and elderly and

long term conditions. The strategy described working with partners, profitability to be able to invest, providing 24/7 care, and driving quality through research, training and innovation. There was an emphasis on clinical services developing integrated models of community care which will enable a significant proportion of patients, spanning every age group to receive high quality care closer to home. The trust planned to deliver general, specialist and tertiary services.

- The core priority for the trust was unscheduled care and the strategy described mechanisms to reduce admissions, redesigning the emergency flow within the hospital, both adult and paediatric, extend the number of Ambulatory Care pathways, and creating a range of Integrated Care Pathways. There had been some progress in models of ambulatory care and 24/7 working. However, many of the areas described were undeveloped and uncoordinated across the trust. There was not evidence of effective strategies supported by plans to deliver improvements in patient care.
- The clinical services did not have clear written strategies but most had identified priorities in response to capacity issues, demand and the trust clinical strategy. Service development varied across the trust and was focused within clinical service centres. Many staff were not clear about their role in delivering the strategy in their service and across the trust. There was not a structured approach to service redesign, trust wide operational planning and integrated pathways of care.

Governance, risk management and quality measurement

- The trust quality governance structure was managed through the governance and quality committee which reported to the trust board. Operational performance and delivery was managed through the senior management team that reported to the trust board. There were groups to manage specific areas of governance, such as medicines management, safeguarding, or serious incidents requiring investigation. Governance arrangements were devolved to the trusts clinical service centres. These service centres held monthly multi-disciplinary governance meetings to review quality, risks and operational performance
- The trust quality improvement strategy 2014 -17 was agreed in September 2014. The strategy had three core elements to provide safe and reliable care; Improve patient experience; and improve clinical effectiveness and outcomes. The trust produced quarterly quality reports covering which included indicators, for example, on avoidable harms, clinical outcomes, mortality, participation in national audits and friends and

family test. Clinical service centres had quality dashboards, which included similar indicators though these were reduced in number and were less specific. These dashboards were in development and did not currently include specific ward based figures, for example, on clinical outcomes, avoidable harms or training. There was infection prevention and control dashboards which covered ward level information. The action taken for indicators which were not being met was not always clarified and evaluated in reports.

- The trust had an integrated performance report which the board reviewed monthly. This included data on performance, quality, finance and the workforce. The information was collated at a trust wide level. The board did not have sub-committee to review operational delivery. Trust board papers were comprehensive but were numerous, detailed and covered the range of strategic and operational priorities.
- The trust corporate governance arrangements were well developed. Papers were well structured to determine issues and actions risk. However, the challenge, assurances and actions agreed and taken by the board in response to key issues, were not always clear.
- The corporate risk register included clinical, organisational and financial risks, and used likelihood and impact/severity criteria for risks to develop a ratings score. The board assurance framework was monitored monthly. This was used to identify the top strategic and operation risks and there was a predictive tool to identify and provide assurance on actual, anticipated, and potential risks. Though the board assurance framework was well developed the intelligence was underdeveloped and some areas were incomplete. The assurance framework was not being used to identify progress against strategic aims. Risks were being plotted but mitigating actions and controls did not always have the desired effect and there was not the evaluation to address issues, for example, some risks remained on target despite the current risk level increasing.
- There were issues affecting quality in the trust's relationship with Carillion, for example, the monitoring of maintenance works, but these had not been addressed in governance arrangements
- Clinical service centre risk registers did not always identify the risks and concerns of staff, Known risks were escalated to the corporate risk register. Mitigating actions and controls were detailed in many areas but these were not always clearly defined and the action taken was not timely. Some risks had been on risk registers for a number of years without clear

resolution. These issues were apparent in the emergency department, medical, surgical and outpatient services. Safety Information was displayed in ward and clinic areas for patients and the public to see.

- The trust had not used clinical audit and internal audit in a coordinated way to review governance arrangements or provide the appropriate breadth and detail around assurance and risks.
- We served two warning notices for the trust failure to respond to patient safety issues in the emergency department and the failure to effectively assess and manage the risks to patients.

Leadership of the trust

- The trust had had stability with a Chief Executive Officer having been in post for 12 years. However, there had been some significant changes to the trust board leadership team over the last 18 months. The Chair was relatively new and had only joined the trust in June 2014 and there was also a new Chief Operating Officer and Director of Nursing in January 2015. The leadership was in the process of change and development. There was the commitment to improve and excel and some directors were clear about their portfolio and areas of action. However, there were gaps in delivery in terms of the performance and operational management.
- The non-executive directors (NEDs) had a broad range of experience. The NED had an understanding of, and commitment to, the safety and quality agenda and were supported to develop their roles. However, the NEDs were not always informed on key trust issues or how the trust was working to resolve key areas of risk. Consequently, there was a lack of rigour in some key challenges and assurances obtained from the board.
- The current Chairman had conducted an assessment of the board after joining the trust to identify capacity and skill shortages. As a result, two new NED and executive director appointments were made. The trust did not have a board development programme to ensure the leadership team was working effectively and there had not been a recent formal assessment of the board's performance. This would be important to ensure sustained improvement.
- The trust had an active and well-structured council of governors whose remit was to advise on the trust's strategic direction, develop trust strategy and to act as guardians of the trust for the local community. The trust had joint board and council of governors meeting and the council described

working with the trust in open and transparent way. Though initially dissuaded, governors now participated in walking the wards and talking to patients. The council of governors led a number of trust advisory groups on best hospital, people and care and planning and performance and had been effective in identifying key issues and improving services. For example, they acted as a critical friend in outpatients and this had led to improvements. However, it was not a model that was being updated elsewhere.

- The leadership team were clear about the strategic direction of the trust, but did not have clarity about how to manage current challenges. The trust had not appropriately recognised some key performance failures or provide leadership to address the issues. There had been strategic work across the wider health economy and this included an independent review in May 2014 to develop an action plan. However, although there was a commitment to resolve issues, this had not been addressed in a timely way. There was an identified 'blind spot' around the challenge of responding to emergency admissions. The problem was seen as "complex" and inevitable based on the local population demographics and it had become clinically acceptable, and part of normal practice, to have patient's queueing in corridors or in ambulances awaiting admission. Staff were aware of the need for change but in some areas felt powerless to respond, and there were not clear pathways of care across clinical service centres, for example, for a coordinate emergency care pathway.
- Many services identified good local leadership but some areas identified the need for more support, this was particularly the case in the emergency department and in some ward areas. Clinical engagement needed to improve across the hospital and there was a lack of clear accountability in some areas about failures in the quality of care.

Culture within the trust

- The values of the trust were described as "Best hospital, best care, best people" . All staff in all areas were aware of the values of the trust and many staff verbalised, and demonstrated, their passion and the committed to ensuring the quality of the service they provide. There trust had a strong ethos of patient centred care. There was a strong sense of team working and staff had a collective responsibility for quality. Staff told us about an openness and transparency about when things go

wrong and staff were supported to report incidents, and to openly discuss openly what they did not know. There were, however, a few areas where staff felt unsupported to be open about concerns.

- Where the trust had identified concerns about leadership and team working, for example, within the colorectal surgery team, these were being handled appropriately.
- The trust's clinical service centres were separately managed units and operationally, there were significant gaps in joined up working. This was particularly evident across the emergency care pathway where escalation procedures were not effective across services to improve the flow of patients in the hospital. Staff also identified difficulties in coordinating referrals for patients with complex conditions.
- The NHS Staff Survey 2014 identified that the trust was similar to other trusts for staff engagement but was in the top 20% of trusts for staff reporting good communication with the senior management team. The staff survey indicated a sustained increase in result compared to previous years across all areas. Staff were positive about the visibility and support of the Chief Executive and many staff at all levels told us they were proud to work for the trust. Many staff had worked in the trust for a number of years, some for their entire careers and some having returned from other jobs. They pointed to the specific culture in the trust where staff, particularly those in leadership roles were open and accessible. A few staff indicated a concern that some leaders in the trust sometimes expected immediate results and this could often be difficult and challenging when working under pressure.
- Feedback from commissioners, stakeholders was that there had been previous difficulties but that relationships had improved and the trust was generally working positively with its partners. While the trust was generally described as open and transparent, it had not actively encouraged appropriate external representation on its key quality committees both from representatives of patients and from other providers, commissioners and stakeholders. Many stakeholders could not understand why the trust was continuing to experience the level of difficulty with it emergency care pathway and why this had not improved at a more rapid pace.

Fit and Proper Persons Requirement

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) to ensure that directors of NHS providers are fit and proper to carry out this important role.
- The trust had undertaken an audit of executive and non-executive directors in November 2012. There were gaps in evidence on person files, for example, evidence of qualifications. These were reported as updated in January 2015.
- The board agreed the FPPR for executive and NEDs in January 2015 and specifically agreed that directors following actions. There to be :
- Additional pre application question for director posts asking if they have been sent to prison in the last 5 years.
- Directors also complete a Fitness to Practice form following offer of a position when they declare any previous convictions.
- Reference request to be amended to specifically request confirmation the director is a fit and proper person under the regulations definition.
- Undertake a free check against the list of Directors which is held by Companies House to verify if a director has been barred as a director or is subject to any restrictions.
- Undertake a credit check on every appointment
- Amend the contract of employment permitting summary termination in the event of a director being/becoming an unfit person.
- Introduce a process of annual self-declaration for all Directors to be undertaken in January each year. To be confirmed during annual appraisal.
- Non-Executive Directors to undergo an annual appraisal.
- We reviewed two personnel files of directors who had recently been appointed. These had had the relevant checks.

Public and staff engagement

- The trust was similar to other trusts for in the NHS staff survey 2013, but most indicators had shown an improvement in previous years. The trust only had three negative indicators and these were for staff agreeing that their role makes a difference, staff reporting errors, near misses and incidents and staff feeling pressure to attend work when feeling unwell.
- Most staff in the trust were positive about engagement. Many mentioned the positive impact of the trust 'Listening into Action' initiative where staff shared their views about what

would make the biggest difference to services. Themes were identified regarding 'what matters to staff' and 'making things better for patients' and action was taken to improve services. Over the past two years, the trust could demonstrate changes and improvements to services based on staff innovations. For example, reduction in theatre equipment wastes, 20% reduction in delayed x-rays, Patient safety issues and 'human factors' training, portering journeys reduced from 230 to 50 per month, centralised referral document improving the speed of internal patient referrals, and phlebotomy handover to junior doctors to minimise missed bloods and errors.

- The trust hold annual Best People Awards and the Chairman Awards to recognise staff achievement. There is also an employee of the month. Staff feedback on these awards was positive. Staff health and well-being was supported and the hospital had a specific centre, called the Oasis Centre, which provided sport and relaxation facilities for staff.
- Many staff told us communication was good across the trust. There was a trust newsletter called 'Trust Matters', the intranet, and teams held regular meetings to support staff engagement. In the critical care unit staff had secure Twitter and Facebook accounts to improve communication.
- The trust had a patient experience strategy was part of the quality improvement strategy and there were two main aims: to demonstrate improvements in patient experience through the Friends and Family Test; and to improve and act upon local patient and family feedback, with a focus on the cancer pathways, dementia care and the discharge process. There was a patient experience steering group to review progress and this group reported to the Governance and Quality Committee. Quarterly reports monitored how information was captured and used to improve services and there were performance indicators for example, on the Friends and family test, mixed sex accommodation and complaints. The trust was in the top 20% of trusts for friends and family test and could demonstrate actions on patient feedback.
- There were examples of patient and public engagement in services, for example, focus groups held by clinical nurse specialists, the memory café for patients with dementia and the dementia café for carers and the trust website was straightforward and accessible. There was partnership working with the Alzheimer's Society, Osteoporosis Society and Solent

MIND dementia carers. There was less evidence of an overall engagement strategy to plan around open days, community working, partnership working with vulnerable groups, newsletters and the use of social media.

Innovation, improvement and sustainability

- The trust commissioning for quality and innovation (CQUINS) priorities included dementia and delirium outcomes, improving response rate to the Friends & Family Test and patient experience metrics. The trust was demonstrating improvements in these areas. The trust however, had been fined by commissioners for not meeting the emergency access four hour waiting time target.
- The trust had a highly innovative culture and staff were encouraged to suggest new ideas to improve service delivery. There were many examples of service improvements developed by the trust and the staff. The trust could demonstrate staff recipients of local and national awards. These award covered research, innovation, education and training.
- The trust's performance was monitored by the Trust Development Authority. As part of its progress to foundation trust status shadow risk ratings are used that are identified by the health regulator Monitor. Risks around the emergency access four hour target, waiting times and c.difficile infections has given the trust a shadow risk rating for service performance of 3 (Amber – Red) and governance risk rating of above 4 (Red), where red is high risk.
- During the year 2014/15, the trust position has forecast a financial deficit of £4.3m. Financial pressures were exacerbated by emergency admissions and staffing costs. The trust was not achieving its cost improvement targets and only 62% had been delivered (a shortfall of £2.3m) had received financial penalties for not meeting performance targets, namely the emergency access target and discharge summaries to GPs. The board but had agreed a range of financial measures and was expecting to make a small surplus of £1.2m this year. The measures were to improve efficiency, clinical coding so that the trust could be appropriately paid, have a temporary reduction in staffing where minimum levels were appropriate, reduce penalties and provide further support and challenge to the clinical service centres around cost improvement plans. The risks around these initiatives were on the trust risk register and board assurance framework in terms of failure to deliver but the quality and safety implications were not identified here and had not been to the trust governance and quality committee.

Summary of findings

- The trust could demonstrate investment in new technology and the use of national resource schemes, for example the trust had been successful with the national “Safer Wards, Safer Hospitals Technology Fund” and the Nurse Technology Fund and was investing in electronic monitoring and reporting and bed management technology for nurses.
- Income was also being generated through research and innovation and teaching. The trust had a research and development department to manage and coordinate research activity and worked in partnership with the local Universities, the Clinical Research Network, the Academic Science Health Network and others develop research with all staff groups.

Overview of ratings

Our ratings for Queen Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Critical care	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding
Maternity and gynaecology	Good	Good	Outstanding	Good	Good	Good
Services for children and young people	Good	Good	Outstanding	Requires improvement	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Outstanding	Requires improvement	Requires improvement	Requires improvement

Our ratings for Portsmouth Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Good	Outstanding	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

- A 'Coffee and conversation' group was held for patients in the stroke wards. This gave patients an opportunity to share their experiences, provide peer support and education. Patients were also given information about support available in the community.
- There were good arrangements for meeting the needs of patients with a learning disability, particularly in theatres. The staff showed good awareness of the specialist support that patients with complex needs sometimes require. Staff used a specialist pain management tool for assessing pain levels in patients who could not verbally communicate their experiences of pain.
- The trust had developed bespoke safeguarding training modules to meet the specific needs of staff and their working environments. For example, there was safeguarding training specific to the issues identified for staff working in theatres and specific types of wards.
- The practice of daily safety briefings on the intensive care unit (ICU) ensured the whole multidisciplinary team were aware of potential risks to patients and the running of the unit.
- In the ICU there were innovative approaches to the development and use of IT systems and social media. Secure Facebook and Twitter accounts enabled staff to be updated about events affecting the running of the service. This included information about risks, potential risks and incidents. Electronic 'Watch out' screens in the unit displayed information about incidents and the unit's risk register. The education team advertised information about training opportunities on the education Twitter account.
- In the ICU, innovative electronic recording systems supported the effective assessment and monitoring of patients.
- The electronic monitoring system used in the hospital for monitoring patients' vital signs enabled staff to review patient information in real time and the outreach team to monitor patients on all wards and prioritise which patients they needed to attend to. This early warning system was developed in response to delayed care in deteriorating patients. Its adoption has saved over 400 deaths, and overall has reduced our mortality levels by 15%.
- Innovative and practical planning of emergency trolleys meant that all equipment needed to manage a patient's airway, including equipment to manage difficult airways and surgical equipment, was stored in a logical order and was immediately accessible.
- In most critical care services, beds are positioned to face into the ward. On some units beds were positioned so that conscious patients could look out of window. Queen Alexandra Hospital's critical care unit had learnt that some patients were frightened when they could not see into the ward and wanted to be able to see into the unit for reassurance. In response, the unit had equipment that could position by beds at an angle so patients could see out of window as well as into the unit.
- In response to difficulties recruiting middle-grade (registrar) doctors, the ICU in partnership with the University of Portsmouth was developing a two-year course in Advanced Critical Care Practice (ACCP). The planned outcome from this course was that ACCPs would be employed in the unit to fulfil some of the medical tasks and release medical staff to do more complicated work. This was the first initiative of this kind in the UK.
- To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the ICU had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care team in the ED, before admission to the unit. The same practice was followed for patients requiring admission to the unit from the general wards.
- The innovative use of grab packs meant staff had instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.
- The critical care unit had developed their own innovative website that included educational information and guidance documents. There was

Outstanding practice and areas for improvement

guidance, tutorials and podcasts from recognised intensive care organisations, Portsmouth intensive care staff and other intensive care staff about the use of intensive care equipment and procedures. This was accessible to staff, staff from other trusts and the general public.

- A perineal clinic had been designed and implemented to provide outpatients care and treatment to women who had sustained third- and fourth-degree tears following delivery. This service enabled women to access treatment sooner than under previous systems. Staff also provided treatment, support, information and education to women who had experienced female genital mutilation.
- There was a telephone scheme for women who had experienced complex or traumatic deliveries to talk about and have a debrief conversation with a midwife following their discharge. The outcomes from the conversations were used as part of the governance processes and this demonstrated a reduction in the number of complaints.
- A mobile telephone application (app) had been developed by the trust and the Chair of the Midwife Liaison Committee together with women who used the services. The app provided information on choices of place of birth and was being developed to include additional information. The app won an award from NHS England in the excellence in people category and the service had also been recognised with an innovation award from Portsmouth Hospitals NHS Trust.
- The multidisciplinary team in the children's and young people's services had made a commitment to creating an open culture of learning, reflection and improvement. This included listening to and empowering and involving staff, children, young people and their families. We found all staff, at all levels, were involved in working towards this goal and this was having a positive impact on improving the safety and quality of services for children, young people and their families.
- There was a new initiative called a 'talent panel', which was a mechanism to discover and develop staff, both for individual career development and the future sustainability of the service. Staff of all grades were encouraged to submit their career aspirations to a panel so that steps to support them could be identified.
- The trust had introduced a volunteer programme for people who wanted to work as a chaplain's assistant. Volunteers were trained on how to support patients through visiting them. Through this training programme, the trust had over 50 volunteers coming to help and support patients.
- The trust received a national award for clinical research impact. The award recognised the trust "Research in Residence Model" and its ability to harness clinical research to improve services and treatments for its patients. The trust identified the development of the early warning system, mobile application for pregnant mothers (cited above), and developing methodologies to reduced respiratory exacerbations and admissions and detect upper and lower gastrointestinal cancer more effectively.

Areas for improvement

Action the trust MUST take to improve

Action the hospital MUST take to improve

- Patients are appropriately assessed and monitored in the emergency department (ED) to ensure they receive appropriate care and treatment.
- Ambulance patients are received and triaged in the ED by a qualified healthcare professional.
- There are effective system to identify, assess and manage the risks in the ED.
- There is an adequate supply of basic equipment and timely provision of pressure-relieving mattresses.
- The cardiac arrest call bell system in E level theatres is able to identify the location of the emergency.
- Medication is prescribed appropriately in surgery and is administered as prescribed in gynaecology.
- The emergency resuscitation trolley on the gynaecology ward is appropriately checked.
- Appropriate standards of care are maintained on ward E3 and the acute medical unit.

Outstanding practice and areas for improvement

- There is a hospital wide approach to address patient flow and patient care pathways across clinical service centres.
- Patients' bed moves are appropriately monitored and there is guidance around the frequency and timeliness of bed moves so that patients are not moved late at night, several times and for non-clinical reasons.
- Patients are allocated to specialist wards, when clinical need requires this, and medical outliers are regularly reviewed by medical consultants.
- Nurse staffing levels comply with safer staffing levels guidance.
- There are adequate numbers of medical staff on shifts at all times.
- All wards have the required skill mix to ensure patients are adequately supported by competent staff.
- The falls action plans are followed in a consistent way across the medical services.
- There is compliance with the WHO Surgical Safety Checklist.
- Staff awareness of standard protocols or agreed indicators for pre-assessment improves to support them in making decisions about the appropriateness of patients for day case surgery.
- Staff on all wards are able to raise concerns above ward level, particularly when this impacts on patient care, and there is a response to these concerns.
- Discharge summaries are sent out in a timely manner and include all relevant information in line with Department of Health (2009) guidelines.
- Staff observe recognised professional hand hygiene standards at all times.
- The surgical high care unit is risk-assessed for infection control risks.
- Medical and dental staff complete mandatory and statutory training.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Nursing handovers provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met.
- Nursing staff are appropriately trained in the safe use of syringe drivers.
- All pharmacists have an appropriate understanding of insulin sliding scales and where such information should be recorded.
- Patient confidentiality is protected so that patients and visitors cannot overhear confidential discussions about patients' care and treatment.
- Records are kept relating to the assessment and monitoring of deteriorating patients in recovery.
- Patient records and drug charts must be complete and contain all required information relating to a patient's care and treatment.
- Do not attempt cardiopulmonary resuscitation forms are completed appropriately and mental capacity assessments, where relevant, are always performed.
- Patient records are stored so that confidentiality is maintained.
- The trust fully participates in all national audits for which it is eligible on end of life care.

Action is taken to improve the leadership where there are services and ward areas of concern.

At a trust level:

- The trust clinical strategy is supported by clear improvement plans and these are monitored and evaluated appropriately.
- Governance arrangements are managed effectively so that there is appropriate assurance around risk and performance.
- The trust board has a development programme and there should be appropriate and timely assessment of its performance.
- There is continued investment in PALS.
- Complaints are appropriately monitored and responded to in a timely manner.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9** HSCA Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people using the service. The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. • The medical outliers were not regularly reviewed by medical consultants. • Patients were not allocated to specialist wards according to their clinical needs. • Nursing handovers did not provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met. Regulation 9- 1 (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10** HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. The provider did not have effective systems to regularly assess and monitor the quality of services provided. • Patients were not appropriately monitored and were moved several times and at night and for non-clinical reasons.

This section is primarily information for the provider

Compliance actions

- Staff were not aware of standard protocols or agreed indicators for pre-assessment improve to support them in making decisions about the appropriateness of patients for day case surgery.
- Some nursing staff on wards did not feel safe in raising concerns above ward level.
- GP discharge summaries were not being sent out in a timely manner and did not include all relevant information in line with Department of Health (2009) guidelines.
- The surgical high care unit had not had a risk assessment for infection control risks.

Regulation 10 (1) (a) (b) (HSCA 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **Regulation 16** Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. The provider did not have suitable arrangements to protect patients and staff against the risk of unsafe equipment or the lack of availability of equipment. • There were inadequate supplies of intravenous pumps, drip stands, pressure-relieving mattresses and other equipment. • The cardiac arrest call bell system in E level theatres was unable to identify the location of the emergency. Regulation 16 1 (a) (2) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulation 20.** HSCA 2008 (Regulated Activities) Regulations 2010 Records.

This section is primarily information for the provider

Compliance actions

The registered person must ensure that the service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of – (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

- The falls action plans were not followed in a consistent way across the medical services.
- Compliance with the WHO Surgical Safety Checklist was not documented appropriately.
- Records relating to the assessment and monitoring of deteriorating patients in recovery were not kept.
- Patient records and drug charts were not complete and did not contain all required information relating to a patient's care and treatment.
- Patient records were not always stored so that patient confidentiality was maintained.
- Do not attempt cardiopulmonary resuscitation forms were not completed appropriately.

Regulation 20 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22** HSCA 2008 (Regulated Activities) Regulations 2010: Staffing. People who use services did not always have their health and welfare needs met by sufficient numbers of appropriate staff at all times. • Nurse staffing levels did not comply with safer staffing levels guidance. • All wards did not have the required skill mix of staff to ensure patients are adequately supported by competent staff. • Medical staffing levels were not as recommended. Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23:** HSCA 2008 (Regulated Activities) Regulations 2010: Supporting Workers. • Medical and dental staff did not meet trust targets to complete mandatory and statutory training. • Nursing staff did not receive formal clinical supervision in line with professional standards. • Nursing staff did not have appropriate training in the safe use of syringe drivers. Regulation 23 1(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9** HSCA Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people using the service. A warning notice was served under Regulation 9 1 (a) (b) In the Emergency Department Patients brought to the emergency department by ambulance were at risk of unsafe care and treatment. The trust had failed to take proper steps to ensure that each service user is protected against the risk of receiving care or treatment that is inappropriate by the means of carrying out an assessment of the needs of the service users and planning and delivering care in a timely way to meet the individual service user's needs. The trust did not take proper steps to ensure the welfare and safety of service users. • National guidance was not followed in the triage and assessment of patients. • A national target had been set that states that ambulance patients should be handed over to the care of emergency department staff within 15 minutes. Figures sent to NHS England showed that the average waiting time to initial clinical assessment by the emergency department at Queen Alexandra Hospital was 25 minutes. • Patients waiting in corridors did not have appropriate monitoring and observation. • Patients who did not receive clinical assessment within 15 minutes were not receiving care or treatment to meet their individual needs and to ensure their welfare and safety. Some patients with serious conditions had been waiting over 60 minutes. • A non-healthcare professional was being used to triage patients.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10** HSCA Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision A warning notice was served under Regulation 10 1 (a) (b) 2 (c) In the Emergency Department • The trust's identified problem with flow had been on the risk register since November 2014. • The recommendations from the Emergency Care Intensive Support Team report (May 2014) had not been implemented. There was a draft and incomplete action plan in August 2014. • The emergency access target was not met and was identified as a major risk on trust risk registers. • Escalation plans did not have sufficient triggers and actions to manage the problems with flow in the emergency department. • The trust had not clearly defined the responsibility with the ambulance service for patients on hospital grounds and patients were at risk. • Staffing levels had not been reviewed in line with changes made to the department. • Changes to the department had been introduced that did not meet national guidance (a healthcare assistant triage process). • At our unannounced visit no progress had been made following the inspection. • The trust had introduced a method to monitor assessment but the process made staff feel 'pressurised' and provided false assurance.

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07 2015

Review of Tamerine Social Care Respite Service

1. Executive Summary

1.1 This paper seeks to outline plans for the future of a social care respite service provided at Tamerine, a four-bedroomed property in Southwick Road, Denmead.

1.2 Tamerine is owned by Southern Health NHS Foundation Trust. TQ21, the Trust's social care arm, and provides social care respite to approximately 23 people with moderate to severe learning disabilities who live in Hampshire.

1.3 Referrals to the service are predominantly made by two local authorities: Portsmouth City Council and Hampshire County Council.

1.4 This report, which is for noting, explains the reasons for the required changes to the service.

2. Contextual information

2.1 TQ21 is the social care arm of Southern Health NHS Foundation Trust. It provides support predominantly to people who have a range of needs in addition to having a learning disability.

2.2 Respite services provide relatives and carers of people with a learning disability a break from their caring role.

2.3 TQ21 is reviewing all of the services and support packages it delivers. The main factor influencing the need for this review is commercial sustainability.

2.4 The social care marketplace is becoming ever more competitive. The national vision for Adult Social Care is for services with greater choice and control for people with learning disabilities. There is significant evidence of a shift in how people want to be supported. This has impacted upon the use of respite services, with individuals now choosing a greater range of alternatives to traditional residential respite. This includes Shared Lives, supported holidays and Direct Payments.

3. Background

3.1 Although it is highly valued, Tamerine has been running at significantly below capacity for several years. Unfortunately, even if Tamerine was to run at full occupancy, it would still not be sustainable.

3.2 Despite considerable efforts, the cost of running Tamerine has been unsustainable for some time. TQ21 has found it increasingly difficult to continue to provide the service in an ever more competitive marketplace.

3.3 Although it is a difficult decision, TQ21 regrettably has no option but to no longer deliver the respite service. It is due to withdraw the service on 20 December 2015, despite the fact this will result in continued financial losses for the organisation.

3.4 Tamerine was last inspected by healthcare regulator the Care Quality Commission (CQC) on 4 September 2014. The service was found to be fully compliant, with all standards being met.

4. Service users, relatives and carers

4.1 Approximately 23 people with moderate to severe learning disabilities in Hampshire and Portsmouth City use the service.

4.2 Hampshire County Council and Portsmouth City Council are working in partnership with TQ21 and have plans in place to look at alternative respite options for the people who currently stay here.

4.3 Earlier this month, families and carers of every person who uses Tamerine were contacted individually by telephone and letter to invite them to a meeting regarding the future of the respite service provided there. Two meetings were held on the same day to maximise the possibility of them being able to attend. The meetings were attended by relatives, carers, representatives from TQ21, and commissioners.

4.4 Plans to close Tamerine and reasons for the closure were discussed, and all present, were given the opportunity to ask questions of senior representatives from TQ21 and commissioners.

4.5 At that same meeting, opportunities were taken to engage with relatives and carers of people who use the service to begin the process of setting up 1:1 meetings with the respective care management team, to arrange a review and assessment of the people affected, so that alternative options could be appropriately discussed.

4.6 A follow-up letter was sent to all relatives and carers. Phone calls were also made to those unable to attend.

4.7 TQ21 will ensure people who use the service, their relatives and carers, and Portsmouth City Council Health Overview and Scrutiny Panel and other key stakeholders are kept fully updated.

5. Staffing implications

5.1 A total of 10 TQ21 staff will be affected by the change. We are working with all staff affected to offer redeployment within Southern Health NHS Foundation Trust. It is not anticipated that there will be any redundancies as a result of this decision.

6. Recommendations

6.1 That Portsmouth City Council Health Overview and Scrutiny Panel members note this report.

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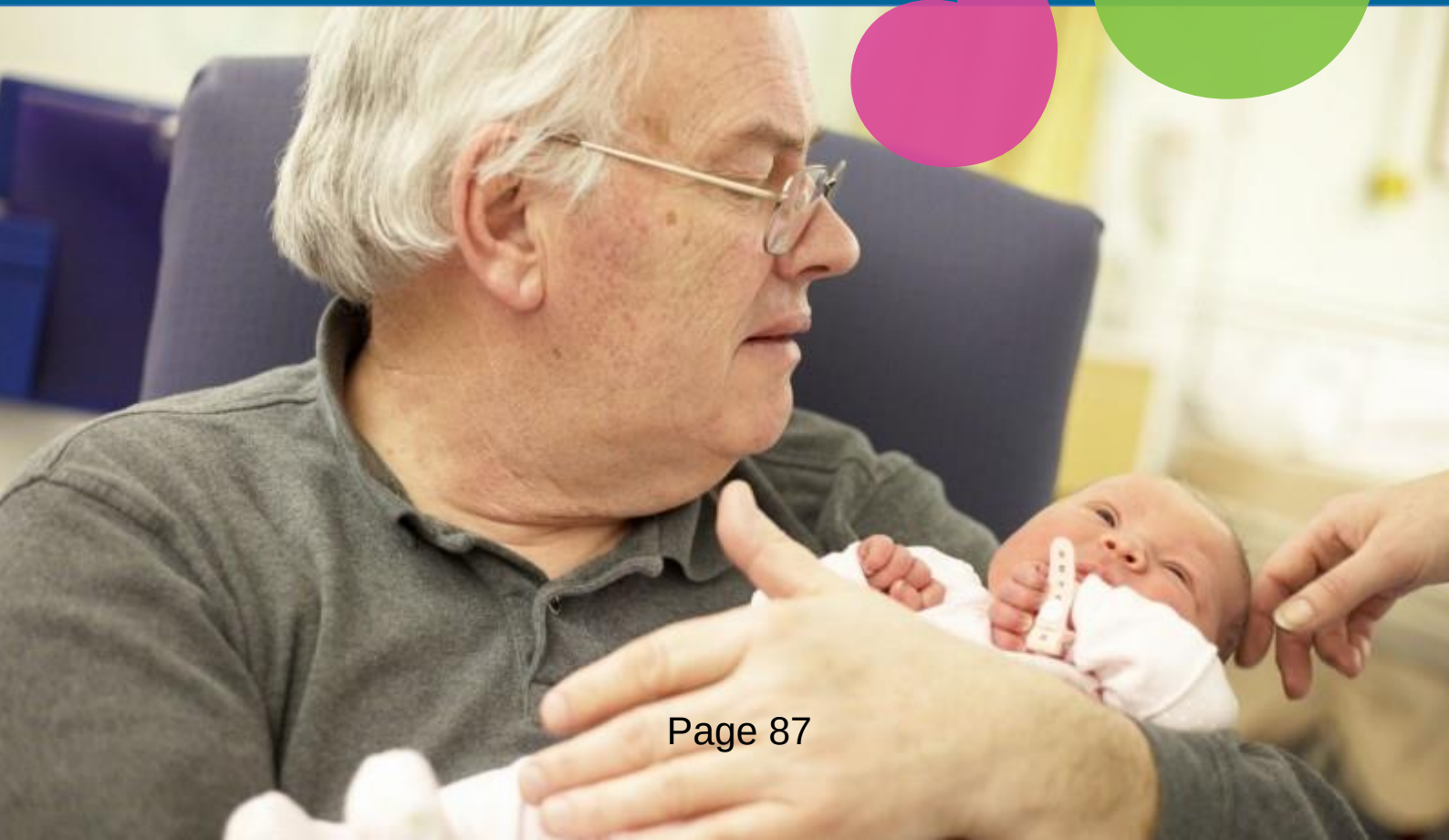
healthwatch Portsmouth

Annual Report Summary

2014/2015



Annual Report Summary

Given the huge pressures on health and social care services change has been inevitable and Healthwatch Portsmouth plays a vital role in ensuring that users of these services can influence change. The last year has helped us to recognise that as a small organisation we can play a vital role working with other organisations on changes to health and social care.

The year has been a challenging one; the first few months involved a process of learning and development for the new board and manager, with time spent finalising the governance structures. We saw the election of new board members, the co-option of additional members, significant staff changes and confirmation that we will face a budget cut in the new financial year beginning in 2015. We have been seeking to establish Healthwatch Portsmouth and were fortunate to retain the services of three of the interim board members, originally involved in the establishment of Healthwatch, which has provided continuity for the board.

Our aim has been to use information given to us by local people to help decide where our focus lies. We also wanted to raise our profile further with the public so that we are clearly recognised as somewhere to go if you have a concern about health issues.

A number of community surgeries were established to make Healthwatch staff available in public spaces. The success of these has continually improved over the course of the year as the service has gained feedback from members of the public on how their needs can be best met. Healthwatch Portsmouth has engaged with a diverse range of Portsmouth residents through attending over 140 events during 2014 -2015.

We also conducted a number of focused activities examples of which include work with Breakthrough, Veterans Outreach Service and the Beneficial Foundation who work with disadvantage groups such as those with learning and other disabilities, and the Portsmouth Disability Forum who offer a wide range of services for disabled individuals and their families.

Examples of community partnerships can be found with work undertaken with Carers, and BME groups including the Cross Cultural Womens Group, Migrant Intervention Project, Carers Council and Carers Centre.

Portsmouth, in recognition of future challenges posed by changing demographics, is transforming services with a view to supporting an aging population. Healthwatch Portsmouth has worked hard to ensure it built appropriate channels to engage with residents who will be impacted by changes to services. We have spoken with residents in care homes, at a range of lunch clubs and user groups, and undertook targeted work on dementia. One of our team is a Dementia Friends Champion and provided Dementia Friends information sessions to groups within the city.

Healthwatch Portsmouth's most effective channel for providing information on local health and social care services has been through its online directory. The directory consists of over 700 Health and Social Care services and is continually growing as we discover new organisations offering support within the city.There were a total of 11,465 searches made on the Healthwatch Portsmouth online directory which is jointly updated with input from Portsmouth City Council.

Healthwatch Portsmouth has aslo been involved in a partnership project called Wessex Community Voice. The Partnership includes NHS England Wessex sub regional team, the Wessex Clinical Senate and Strategic Clinical Networks and five local Healthwatch that operate across the region; Dorset, Hampshire, Isle of Wight and Southampton.

This innovative project developed a framework for good practice and a step-by-step guide to Patient and Public engagement in commissioning that has since been well received by stakeholders across the region.

Local people received indepth training over a series of five one day session that covered the commissioning process and support their understanding and ability to engage in the design of services. More information can be found via this link:

https://www.youtube.com/watch?v=-Gw4DjSUvIQ

As an independent organisation Healthwatch Portsmouth was able to voice patient experience, identify learning points and areas for improvement. We have instigated a commitment to identify Mental Health Champions within a Trust's Community Care Services and contributed on a serious recent case review panel to ensure that agency action was challenged and identified areas for change.

Healthwatch Portsmouth has also been active in monitoring CQC findings and reports to supplement its knowledge of the local Health and Social Care landscape.

Opportunities and challenges for the future

Healthwatch Portsmouth continues to build positive working links with providers of services within the city. Our strategy has been to pursue a partnership approach to investigating and resolving those issues reported to the service. It is our belief that through encouraging joint ownership of user experience the service enables change by forming a consensus on any required change.

We will face a significant challenge this coming year having received a 30% cut to funding. To meet these challenges we will need to place increasing emphasis on recruiting and training volunteers to increase capacity and deliver more for less.

Regular activities will be appraised and rebalanced to account for the loss of staff, and outreach increasingly targeted to suit the available resources

New contract performance indicators agreed with Portsmouth City Council will support us to put local voice at the heart of projects, and success will be measured in terms of the change the service is able to effect.

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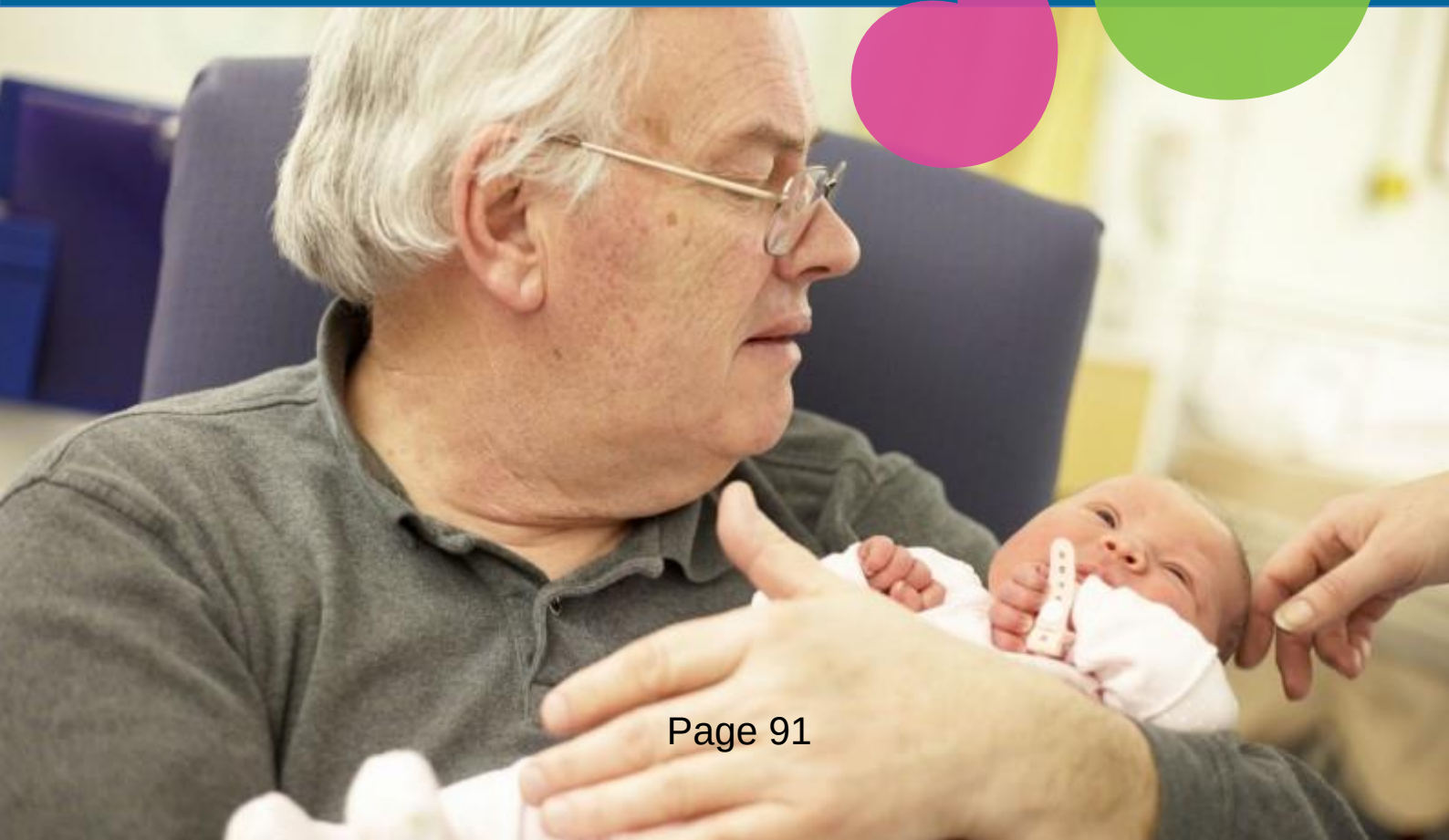
healthwatch Portsmouth

Annual Report

2014/2015



Contents

Note from the Chair

The year covered by this annual report has been a challenging one for Healthwatch Portsmouth. It has seen the election of new board members at the beginning of 2014, co-option of additional members, significant staff changes and confirmation that the budget for Healthwatch will face a cut in the new financial year beginning in 2015.

At the same time Healthwatch Portsmouth has been seeking to establish itself. We were fortunate to initially retain the services of three of the interim board members, originally involved in the establishment of Healthwatch, who were elected and provided some continuity for the board. We welcomed a new manager following the departure of a predecessor to become the manager of Healthwatch Hampshire.

The first few months involved a process of learning and development for the new board members and the manager and some time was spent finalising the governance structures for Healtwatch Portsmouth. The Board agreed to pursue three areas of interest and develop a specific project in each. The three areas were mental health, cancer services and medical equipment.

As part of the Board development process a session was arranged with an external facilitator and one of the agreed actions was to appoint a permanent chairman of the Board rather than rotating it among members. Three new co-opted members were also recruited and joined the Board in October 2014.

I was one of the new members recruited and was appointed chairman of the Healthwatch Board in December 2014.

We also agreed to appoint a vice-chairman. Following the departure of our Healthwatch manager in December we recruited a new manager.

Given the huge pressures on health services change is inevitable and Healthwatch can play a vital role in ensuring that users of these services can influence change. The last year has helped us to recognise that as a small organisation we can play a vital role working with other organisations on changes to health and social care.

We will use information given to us by people in the city to help decide what we should be working on. Raising our profile further with the public so we are clearly recognised as somewhere to go if you have a concern about health issues is one of our priorities for the next year.

We can then ensure that Healthwatch Portsmouth has a strong foundation on which to build for the future.

Graham Heaney

Chairman of the Healthwatch Board

May 2015

About Healthwatch

We are here to make health and social care better for ordinary people. We believe that the best way to do this is by designing local services around their needs and experiences.

Everything we say and do is informed by our connections to local people and our expertise is grounded in their experience. We are the only body looking solely at people's experience across health and social care.

We are uniquely placed as a network, with a local Healthwatch in every local authority area in England.

As a statutory watchdog, our role is to ensure that local health and social care services, and the local decision makers, put the experiences of people at the heart of their care.

Our vision

Our vision is for Portsmouth to be served by high-quality health and social care services where public voice helps shape and improve provision within the city.

Our mission

We will:

Employ multiple communication channels to reach out to and listen to Portsmouth's health and social care consumers.

Work closely with the voluntary, public and private sectors to enable them to deliver accessible, high quality care based on consumer evaluation, participation and research.

Employ a partnership approach with key stakeholders and volunteers, to applaud, challenge, question and review in the pursuit of best practice in health and social care, informed by the consumer's opinion.

Contribute the consumer voice to the deliberations and strategy of the Health and Wellbeing Board. We will contribute to Portsmouth's Joint Strategic Needs Assessment as an evidence base for health and social care. Support Healthwatch England's strategy for local and national improvement.

Be entrepreneurial to achieve our goals.

Our local priorities

The local priorities for Healthwatch Portsmouth in 2014 – 2015 included further developing governance arrangements to provide a sound platform from which to direct the services activities, and undertaking meaningful enquiries into issues identified through the board's knowledge of local needs.

Those areas identified as having research potential included: access to mental health services, the supply of medical equipment, cancer services, dementia services, Emergency Department waiting times, and GP services

Following an appraisal of questions relating to each area, Mental Health, Medical Equipment and Cancer Services were identified for further project work and a series of Project Initiation Documents were bought to the Healthwatch Portsmouth Board for consideration.

Healthwatch Portsmouth delivers eight statutory functions:

1. Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.

2. Enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved;

3. Obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known;

4. Making reports and recommendations about how local care services could or ought to be improved. These should be directed to commissioners and providers of care services, and people responsible for managing or scrutinising local care services and shared with Healthwatch England.

5. Providing advice and information about access to local care services so choices can be made about local care services;

6. Formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with Healthwatch England.

7. Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about particular issues.

8. Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

Additional to its statutory functions, Healthwatch Portsmouth also delivers an independent NHS Complaints Advocacy for local residents which provides increased awareness of issues with services and an addition route to effect change.

Engaging with people who use health and social care services

Understanding people's experiences

In 2014 – 2015 Healthwatch Portsmouth has delivered a comprehensive and inclusive engagement strategy that has reached out to thousands of people within the city.

The service has used a developing network of partner organisations to facilitate access to the views of diverse range of local people.

Face to face engagement activities have included a mixture of one to one interviews, focus groups and broader survey activity as appropriate to the audience and enquiry being undertaken.

Healthwatch Portsmouth has engaged with a diverse range of Portsmouth residents through attending over 140 events during 2014 -2015.

In addition to direct work with the public, a wide range of digital and social media has been used to undertake surveys, promote debate, and to support people to speak up about their experience of Health and Social Care services.

A number of community surgeries have been established to make Healthwatch staff available in public spaces. The success of these has continually improved over the course of the year as the service has gained feedback from members of the public on howtheir needs can be best met.

The Portsmouth Health Café

The Portsmouth Health Café provides an accessible and friendly environment for local residents to drop in and talk about their Health and Social Care needs. Run in Partnership with Portsmouth Disability Forum, this event extends the reach of the Healthwatch network

Launched in December, attendance at the event has continually improved with new visitors to the forum each month.

Representatives from the Portsmouth CCG attended to answer questions about the commissioning and delivery of local services.

How Healthwatch Portsmouth gained the views of:

Young people (under 21)

Our partnership with the University of Portsmouth has provided a fantastic route to gaining the views of young people living in the city, and the service has actively explored opportunities to involve students in the delivery of the service as volunteers, or through undertaking community research as part of their studies.

This year saw changes for children and young people with a special educational need or disability (and their families). The introduction of the Portsmouth local offer, and roll out of Education Health and Care Plans (EHCP) saw us engage with Portsmouth Parent Voice to monitor progress and gain feedback.

Older people (over 65).

Portsmouth, in recognition of future challenges posed by changing demographics, is transforming services with a view to supporting an aging population. Healthwatch Portsmouth has worked hard to ensure it built appropriate channels to engage with residents who will be impacted by changes to services. The service has spoken with residents in care homes, at a range of lunch clubs and user groups, and undertook targeted work with the Alzheimer's Society through attendance at local Memory Cafés.

People volunteering or working in our area but who may not live in our area.

Healthwatch Portsmouth has not prioritised engaging with people who live outside of the Portsmouth boundaries, although our friendly staff have taken comment on local services where offered.

A busy calendar of community events across the city has seen us speak with users of local services including non-Portsmouth residents. Further, work to promote awareness of the service with Portsmouth City Council, the University of Portsmouth, and our extensive network of partner agencies and members, has seen a broad range of comment from people working within the city.

Engagement with groups helping Vulnerable or Disadvantaged People

Disadvantaged and vulnerable individuals often are most dependent on Health and Social Care services. In recognition of the needs of the local community the services continually looks to ensure that it is giving voice to those people who are most affected by the changing nature of provision.

In response to information gathered the service has undertaken a number of focused activities examples of which include work with Breakthrough, Veterans Outreach Service in recognition of the city's links to the Royal Navy, the Beneficial Foundation who work with disadvantage groups such as those with learning and other disabilities, and the Portsmouth Disability Forum who offer a wide range of services for disabled individual and their families.

People who are seldom heard.

Healthwatch Portsmouth recognises that those individuals with the highest needs face often the greatest barriers to voicing their experience.

Through partnership arrangements the service has worked with key agencies to ensure that the voices of communities that struggle to find representation are heard.

Examples of community partnerships can be found with work undertaken with Carers, and BME groups including the Cross Cultural Womens Group, Migrant Intervention Project, Carers Council and Carers Centre.

One of our team is a Dementia Friends Champion and provided a Dementia Friends information session to twelve women and providing them with more of an understanding of dementia and things that could make a difference to people living within their community.

Enter & View

Healthwatch Portsmouth has not exercised its power to enter and view during the 2014-2015 reporting period.

Work to support the transition between service managers and the ongoing development of governance processes has taken priority over progressing an Enter and View strategy; the service instead focusing on building a solid and sustainable platform from which to grow.

Healthwatch Portsmouth contracted provider, Learning Links, has delivered training to other local Healthwatch organisations, which stands Healthwatch Portsmouth in good stead for delivering a successful Enter and View strategy in the 2015-2016 year.

It stands to note that the lack of Enter and View activity has not precluded Healthwatch Portsmouth from engaging with users of services within a care setting.

Through partnership building and a consensual approach to soliciting public voice, access has been granted to a range of care settings to gain the views and experience of provision.

Healthwatch Portsmouth has found where a provider is actively engaged in facilitating independent scrutiny of their provision. This is supportive of effecting positive change as a result of any feedback obtained.

Providing information and signposting for people who use health and social care services

Helping people get what they need from local health and social care services

Healthwatch Portsmouth's most effective channel for providing information on local health and social care services is through its online directory.

Healthwatch Portsmouth recognises that where possible, the most efficient way to put people in touch with the services they need is to provide up-to-date accessible information to enable them to make an informed choice on the most appropriate service to meet their need.

In promoting self-direction for the volume of its signposting, the service is able to focus its limited resources on those complex enquiries, and instances where individuals have an urgent need for information.

The service directory ranks well on google and regularly receives over 1,000 hits per month.

11,465: The number of searches made of the Healthwatch Portsmouth online directory.

This electronic resource is strengthened as responsibility for updating information and promoting it to the public is shared jointly with Portsmouth City Council.

The directory consists of over 700 Health and Social Care services and is continually growing as we discover new organisations offering support within the city.

Where direct enquiries are made to the service by email, telephone, or as a product of engagement activities, the service has gained further valuable insight into the needs of Portsmouth residents and stakeholders.

The service has noted a wide range of agencies within the city have directed the public to Healthwatch Portsmouth support, and the service will aim to build on this trend to increase its reach.

Value has been added to residents through ongoing research of local provision, and where our resources are defined by geographic boundaries, the service is able to utilise its strong working relations with neighbouring local Healthwatch organisations to ensure that people get the information they need.

Healthwatch Portsmouth has an ambitious plan for developing its directory and signposting service to ensure that feedback from residents continues to shape the way we deliver this service.

A range of developments are under consideration for this year from improving accessibility of CQC ratings, to adding more refined search options a range of developments are under consideration for the coming year.

Influencing decision makers with evidence from local people

Producing reports and recommendations to effect change

The service recognises that the production of reports is a development area and has an action plan in place to address this for the 2015-16 reporting period.

The service has however brought about change through making recommendations and as a result of its participation in operational and strategic forums where through shared learning, the needs of Portsmouth residents have been recognised.

A new reporting format has been designed in collaboration with Portsmouth City Council to support with evidencing the change that has resulted from work undertaken.

This move is welcomed by Healthwatch Portsmouth and the service has revisited its priorities to ensure that the scope of projects undertaken is achieveable in light of the resource available.

"Healthwatch Portsmouth's involvement was crucial in providing a strong voice of challenge to agencies, in particular health, and providing an insight into how the child at the centre and their family may have experienced agency actions."

Helen Donelan, Portsmouth Safeguarding Children Board.

Putting local people at the heart of improving services

Healthwatch Portsmouth has been involved in a partnership project called Wessex Community Voice. The Partnership includes NHS England Wessex sub regional team, the Wessex Clinical Senate and Strategic Clinical Networks and five local Healthwatch that operate across the region; Dorset, Hampshire, Isle of Wight and Southampton.

This innovative project developed a framework for good practice and a step-by-step guide to Patient and Public engagement in commissioning that has since been well received by stakeholders across the region.

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More information can be found via this link:

https://www.youtube.com/watch?v=-Gw4DjSUvIQ

The Healthwatch Portsmouth representative on Portsmouth City Council's Health and Wellbeing board has been supported through a regular series of advisor meetings.

The advisor meetings allow the strategic team to come together to discuss feedback from board members and operational activity, to support the manager with any emerging issues, and to discuss and set priorities.

Regular interaction between the board and operational team has supported an increasingly consistent direction of the service which in turn has added value to our input to the Health and Wellbeing Board.

Working with others to improve local services

Healthwatch Portsmouth continues to build positive working links with providers of service within the city. Our strategy has been to pursue a partnership approach to investigating and resolving those issues reported to the service. It is our belief that through encouraging joint ownership of user experience the service enables change by forming a consensus on any required change.

There is scope for Healthwatch Portsmouth and the Care Quality Commission to work more closely together. This might be accomplished through a more structured approach including the planning of joint activities, improved sharing of information, and feedback on actions undertaken as a result of the interactions between services.

"Healthwatch Portsmouth has been brought together with the council and CCG to develop effective relationships.

Over the course of the year the major suppliers in the city underwent inspection by the CQC as part of their schedule.

Healthwatch Portsmouth has been active in monitoring CQC findings and reports to supplement its knowledge of the local Health and Social Care landscape.

During the inspection of Queen Alexandra Hospital, Healthwatch Portsmouth supported the CQC at a public engagement event with information on local issues and by supporting with knowledge of public engagments.

"Partners believe Healthwatch is empowered to act as an independent and effective voice for users, communities and the public."

Portsmouth Health and Welbeing Board self-assessment.

As a result of the partnerships built with local providers, where information has been requested to support enquiries undertaken by the service this has been supplied without issue.

The service has supported engaging the public in local issues through inviting key decision makers and organisational leaders to speak at board meetings held in public. At these events, time is allocated for members of the public to ask questions of the speaker.

Healthwatch Portsmouth has maintained regular communication with the Healthwatch England regional development officer and has benefitted from the support of the national organisation. The service has supplied information to support the 'big picture' through the scheduled intelligence returns and ad hoc feedback where significant issues have been found.

Impact Stories

Case Study One

Serious Case Review.

Our Advocate, Fergus Cameron, has contributed on a recent case review panel to ensure that agency action is challenged and to identify areas for change.

As an independent organisation Healthwatch Portsmouth was able to voice patient experience, identify learning points and areas for improvement.

Through its wider work the service undertstands that parents of children with newly diagnosed disabilities experience a range of emotions and that it can be difficult to process information or manage the sudden engagement with an array of health professions and processes.

This can be overlooked by a range of professionals, especially where there is a perception that an individual link professional is responsible for supporting the family.

Healthwatch Portsmouth voiced a parents priorities included wanting to ensure care of their child to be comfortable, to enjoy ordinary but essential daily living activities, to participate in their child's care and maintain their parental relationship, to exercise choice, and to consider options and alternative providers of healthcare and medical approaches.

Feedback to the review included the importance of continuity in relationships with the family, particularly in the maintenance of the Nominated Link Nurse, An awareness of timing and commitment to agreed actions, as when these do not happen the parents lose trust and felt not listened to.

There was a missed opportunity to develop new skills in delivering care (for Parents) through direct training from the nursing team in a partnership approach. This would have allowed clinical staff to assess the parent's competence to deliver care independently, could potentially have improved relationship between staff and parents, and offered greater preparation for for hospital discharge.

Feedback from the Portsmouth Safegarding Childrens Board is as follows.

"Fergus Cameron acted as Healthwatch representative on a recent case review panel into concerning circumstances around a Portsmouth child.

The role of the panel is to oversee and scrutinise the development of the review and the resulting report; ensuring that we are effectively challenging agency action and identifying areas for change.

Healthwatch involvement was crucial in providing a strong voice of challenge to agencies, in particular Health, and providing an insight into how the child at the centre and their family may have experienced agency actions.

Fergus guided the panel through the narrative of health involvement from the perspective of the family. His insight into the everyday functioning of health provision and the patient experience enabled the panel to achieve a strong understanding of the quality of the agency practice, and more robustly identify learning for improvement."

Case Study Two

Mental Health Champions.

Healthwatch were asked by an older man in ill health, and his daughter the main carer, to support them in their difficulties with the community health team. His poor health was resulting in repeated hospital admissions and he had Nursing and Domiciliary Care Agencies supporting him at home with several visits throughout the day.

His daughter felt a responsibility to supervise and engage with the care package, which led to growing conflict with the care providers, the relationship broke down to the extent that the lead professional notified the father that services were at risk of being withdrawn and that no alternative provider could be identified.

The daughter had a range of complaints about care coming in but the focus of the complaint was on the perceived threat of removal of service and criticism of her behaviour, this was being described as aggressive and verbally abusive to staff.

The conflict and breakdown in relationship with father and daughter resulted in a failure to listen to the daughter and acknowledge her history of mental health difficulties, these were pronounced and included periods of hospital admission and section under the mental health act.

The care services had become defensive and entrenched unable to communicate effectively or respond flexibly.

Healthwatch involvement highlighted the level of threat that the gentleman and his daughter were experiencing, the daughter's reaction to her father's declining health and end of life approaching.

Healthwatch identified the mental health difficulties that the daughter was experiencing and her growing anger that this was not being listened to, that she was being labelled as badly behaved.

The Trust delivers Community Adult Mental Health Services but no connection was being made with their generic primary community care teams.

Healthwatch advocated that the family were being threatened and that the daughter, carer, needed additional mental health support, and that the Trust already had the specialist services.

By early intervention on the complaint and joint working with the investigating officer the daughter's mental health needs became part of the care plan and package. The Trust acknowledged that mental health training and development should be developed and easier access to supporting mental health specialists.

This has become a commitment to identify Mental Health Champions within the Trust's Community Care Services and the learning from this was shared by Healthwatch when invited to the Trust's Clinical Governance meeting.

Opportunities and challenges for the future

Healthwatch Portsmouth will face a significant challenge this coming year having received a 30% cut to funding.

The city of Portsmouth is undergoing significant change and there is an increasing need to ensure that local people are involved in the decisions that will impact upon the provision of the health and social care services they use.

To meet these challenges we will need to place increasing emphasis on recruiting and training volunteers to increase capacity and deliver more for less.

Regular activities will need to be appraised and rebalanced to account for the loss of staff, and outreach increasingly targeted to suit the available resources.

New contract performance indicators agreed with Portsmouth City Council will support us to put local voice at the heart of projects, and success will be measured in terms of the change the service is able to effect.

The partnerships developed over this last year will become increasingly important in broadening the service's reach to ensure awareness of, and engagement with Healthwatch Portsmouth continues to grow.

Our governance and decision-making

Our Board

Graham Heaney (Chair)

Roger Batterbury (Vice Chair)

Mike Baker (Elected Board Member)

Jennie Brent (Elected Board Member)

Ken Ebbens (Elected Board Member)

Sameen Farouk (Elected Board Member)

Lynne Rigby (Elected Board Member)

Geoff Jacobs (Co-opted Board Member)

Dr Nick Murdoch (Co-opted Board Member)

Tony Horne (Board Advisor: University of Portsmouth)

Matthew Gummerson (Board Advisor: Portsmouth Cith Council)

Zoe Gray (Board Advisor: Learning Links)

How we involve lay people and volunteers

Healthwatch Portsmouth is well served by a board comprised of local community leaders and experts and lay people. The board participate in an array of forums relating to the quality and design of services within the city, and use feedback from residents of Portsmouth when influencing decisions.

Volunteer representatives of Healthwatch Portsmouth have been actively involved in the audit and procurement of local services, and members of staff have attended a wide range of regional and local forums to represent the interests of the local public.

In addition, the extensive network of public and professional stakeholders developed by Healthwatch Portsmouth is regularly used to promote public participation at engagement events across the city.

Our governance documents have been co-designed and ratified via the Board during meetings in public. Volunteer role descriptions have been designed in conjunction with a group of volunteers thus ensuring that volunteers are clear about their roles within our delivery and to whom they are accountable.

Financial Information

Financial Year 2014/15 (1st March to 30th April)

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	£98,767
Funding received from local authority to deliver Independent NHS Advocacy activities	£49,384
Additional income (NHS Wessex Community Voices Project)	£4,500
Total income	£152,651

EXPENDITURE	
Office costs	£26,756
Staffing costs	£90,338
Direct delivery costs	£32,467
Total expenditure	£149,570
Balance brought forward	£3,081

Contact us

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Hampshire,
PO1 3EY.

Phone number: 023 9397 7079

Email: info@healthwatchportsmouth.co.uk

Website URL: http://www.healthwatchportsmouth.co.uk/

We will be making this annual report publicly available by 30th June 2015 by publishing it on our website and circulating it to Healthwatch England, Care Quality Commission, NHS England, Clinical Commissioning Group, Portsmouth City Council Overview and Scrutiny Committee/s, and Portsmouth City Council.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.