

Portsmouth Hospitals NHS Trust

Quality Report

Queen Alexandra Hospital
Southwick Hill Road
Portsmouth
PO6 3LY
Tel: (023) 92286000
Website: www.porthosp.nhs.uk

Date of inspection visit: 10 and 11 May 2017
Date of publication: 24/08/2017

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	Not sufficient evidence to rate	
Are services at this trust safe?	Not sufficient evidence to rate	
Are services at this trust effective?	Not sufficient evidence to rate	
Are services at this trust caring?	Not sufficient evidence to rate	
Are services at this trust responsive?	Not sufficient evidence to rate	
Are services at this trust well-led?	Not sufficient evidence to rate	

Summary of findings

Letter from the Chief Inspector of Hospitals

Portsmouth Hospital NHS Trust is located in Cosham, Portsmouth and is a 975 bedded District General Hospital providing a comprehensive range of acute and specialist services to a local population of approximately 610,000 people. The trust provides specialist renal services to a population of 2.2 million people across Wessex. On our announced inspection on 10 and 11 May 2017, we inspected the key question of 'well led' for Portsmouth Hospital NHS Trust.

We carried out a responsive focused inspection of the corporate and leadership functions of Portsmouth Hospital NHS Trust on 10 and 11 May 2017, inspecting the key question of 'well led'. This inspection was carried out following our inspection of the emergency medical pathway in February 2017 which highlighted concerns regarding culture, governance and leadership within the trust. The specific concerns required us to visit the emergency department and medical care areas as part of the May 2017 inspection in order to review ward to board governance arrangements. During this May 2017 inspection we identified concerns in the emergency department, four medical care wards and the Acute Medical Unit (AMU). The findings are reported in the February 2017 report for the emergency department and medical care services for Queen Alexandra Hospital. To view our findings and report from the February 2017 inspection of the Queen Alexandra Hospital please refer to our website.

During this inspection, we found that there had been deterioration in the quality of services provided, and that improvements had not been sustained. Immediately following our inspection of Queen Alexandra Hospital in February 2017 inspection we issued enforcement action under Section 31 of the Health and social Care Act 2008 to protect patients on the acute medical pathway from the immediate risk of harm. During this inspection, in May 2017, we did not see evidence that services had sufficiently improved following our feedback to the trust senior leadership team in February 2017. Following our inspection of Queen Alexandra Hospital in May 2017, we served further action under Section 31 to protect vulnerable patients from immediate risks of harm. Details of these notices are included at the end of this report.

There was a lack of management oversight and lack of understanding of the detail of issues which we observed on both inspections. We found that the trust had significant capacity issues and were not addressing the concerns regarding the acute medical pathway in a timely or effective way. The pressure on beds meant that patients were allocated the next available bed rather than being treated on a ward specifically for their condition placing patients at risk of harm. Across all areas inspected there were significant concerns regarding the care for vulnerable patients and the application of the Mental Health Act 1983, Mental Capacity Act 2005, and Deprivation of Liberty Safeguards.

We have not rated the well led element for Portsmouth Hospital NHS Trust as we did not collate sufficient evidence to do as we had only inspected in relation to the emergency department and medical care areas. However, there were significant concerns in safety, responsiveness and leadership, with an apparent disconnect between the trust board and the ward level. It was evident that the trust leaders were not aware of many of the concerns we identified through this inspection. Staff perceived there was bullying and did not feel able to speak out about concerns. We were not assured that the processes for raising concerns internally were open and free from blame.

Our key findings were as follows:

- There was a lack of leadership oversight of mental health provision at all levels.
- Not all staff complied with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards. We raised five safeguarding alerts to the trust for reporting to the local authority during the inspection.
- We found that in the majority of areas the staff were committed to providing the best care they could with the resource levels, skills and training within the area they were working in.
- Several staff were identified by the inspection team as being strong in their work.

Summary of findings

- The process for the induction of agency nurses across the trust was not effective. This was because the process for formal checks on the nursing competencies for the administration of IV fluids on the wards was inconsistent.
- We were concerned that the emergency department medical staff were working outside the scope of their clinical skills and competencies. The emergency department staff were providing acute medical care to patients due to the medical staff not willing to take medical patients outside of their specialist area. This placed the emergency medical doctors at risk.
- The medical model for acute care was to be launched on 8 May 2017 but some doctors refused to take part in implementation of the model. There were insufficient mitigations in place and this meant emergency department doctors were caring for medical patients for extended periods of time.
- The culture of medical staff throughout the medical division and unscheduled care was of significant concern to us. We found that there was a culture that was not supportive to patient safety, quality or care. This resulted in delays for patients to receive medical care.
- Following CQC enforcement action in March 2016, the trust had appointed an Executive Director of the Emergency Care pathway. During our interviews there was a lack of clarity from the Medical Director and the Executive Director of Emergency Care pathway as to who held executive accountability and responsibility for the acute medical pathway.
- Delayed care and breaches of the four hour timeframe and 12 hour trolley breaches appeared to be normalised.
- Mortality has increased at a steady rate over the last 12 months. We were not assured this was being addressed. We were informed that mortality was high due to the 'unscheduled care pathway'. However no audits or evidence had been gathered to support this. Since the inspection, the trust has provided information which demonstrates they are working to improve their processes for monitoring mortality.
- We were significantly concerned about the processes and practice for safeguarding adults and children within the trust. We were not assured that all known events were being appropriately reported or investigated as safeguarding concerns.
- The safeguarding children training rates at level three were significantly below what would be expected in some departments including the emergency department.
- We were made aware of two incidents involving children that demonstrated the trust did not follow best practice safeguarding children procedures.
- We were significantly concerned about the lack of oversight on safeguarding matters within the trust at senior management and executive board level.
- The governance processes to highlight issues within the trust were not effective.
- The private board papers, in the majority, should have been shared in public board to demonstrate an open and transparent approach from the trust.
- There was a backlog of complaints, and the quality of complaint responses was variable. Some responses did not fully address the concerns raised by the complainant.
- The quality of incident investigations were very poor. There was limited evidence or assurance that lessons learned from incidents were implemented.
- The application of the Duty of Candour regulation to incidents was variable, with incidents found where duty of Candour had not been undertaken.
- We received several positive examples of good practice and positive experiences from staff working throughout the hospital.
- However, many staff perceived there was bullying and didn't feel able to speak out about concerns. This was expressed by different staff groups who raised concerns to CQC before, during and after the inspection.
- We were not assured that the processes for raising concerns internally were open and free from blame. This discouraged staff from feeling free to speak about concerns.
- The role of the trust's freedom to speak up guardian was not working effectively. Staff we spoke with in the majority were not aware of who the freedom to speak up guardian was.
- The process for checking if a person working at board level in the organisation is fit and proper to work in their role, was undertaken in accordance with the regulations.

Summary of findings

- There was work being undertaken to ensure compliance with the workplace race equality standards.
- Most specialties provided care and treatment in line with NICE guidelines and royal college guidelines. Trust policies were in line with these guidelines
- During 2015/2016, 38 national clinical audits and eight national confidential enquiries covered NHS services that Portsmouth Hospitals NHS Trust provides. During that period Portsmouth Hospitals NHS Trust participated in 97% (37/38) national clinical audits and 100% (8/8) national confidential enquiries of those it was eligible to participate in
- Between November 2016 and February 2017, 96% of patients said they would recommend the trust to family and friends, higher than the national average of 95%.
- Between November 2016 and March 2017 93% of patients said they would recommend the A&E service to family and friends, higher than the national average of 87%
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included stroke pathways, sepsis, acute kidney injury, non-invasive ventilation and falls
- During 2015/2016, Portsmouth Hospitals NHS Trust has participated in a total of 316 clinical research studies, 84% of these studies were NIHR Portfolio adopted.
- There was an improved and dedicated focus to providing care to patients with a learning disability.
- Many staff reported good experience of culture and openness within their local departments
- In areas such as paediatrics, maternity and critical care staff provided good examples of how leadership and culture was positive in their areas. This included being open and raising concerns.

For the areas of poor practice the trust needs to make the following improvements.

Importantly, the trust must:

- Ensure that staff are assessed and signed off as competent to deliver patient care.
- Ensure that the culture within the organisation of staff not being willing to raise concerns openly and concerns around bullying are given sufficient priority by the board.

- Review the governance functions and processes for the trust to ensure they are fit for purpose.
- Improve compliance with regulation 28 coroner reports for preventing future deaths.
- Ensure that improvements are made to the classification of incidents to ensure that they are reported, escalated and graded appropriately.
- Ensure that the conditions imposed by the Commission on the Acute Medical unit, and Emergency Department are effectively implemented.
- Improve identification and management of incidents requiring duty of candour.
- Improve the quality of Root Cause Analysis investigations.
- Review the processes for the safeguarding of vulnerable adults and children the ensure that safeguarding processes work effectively in the trust.
- Improve the processes, policies, staffing and understanding of mental health for staff at ward to board level.
- Ensure that staff have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards, and implement them effectively.
- Ensure that patients do not have procedures undertaken on them without appropriate consent being obtained, and best interest assessments are completed where applicable.
- Ensure that records completed for the purpose of care are completed accurately.
- Immediately review the risks associated with reporting of chest x-rays in radiology. Including the undertaking of a patient harm review on all cases not reported on.
- Undertake patient harm reviews and audits to identify where lessons can be learned or mortality ratios reduced.
- Immediately review the medical model within acute care to ensure that patients are seen by a treating physician and treated at the earliest opportunity.
- Improve the flow and capacity throughout the hospital.

Summary of findings

- Review the board assurance framework, board minutes, and processes for reporting at board to ensure risks are identified and managed by the trust, and that the minutes are appropriately recorded.
- Develop a vision and strategy for the trust.
- Improve the complaints processes, oversight of complaints and reduce the backlog of complaints to ensure patients receive responses in a timely way.

Following the inspections of the Queen Alexandra Hospital in February and May 2017 we took immediate action to ensure the safety of patients. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we did not do so. Details of this action are included at the end of the report.

Professor Sir Mike Richards Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Portsmouth Hospitals NHS Trust

Sites and Locations:

The trust has four registered locations;

- Queen Alexandra Hospital,
- Gosport War Memorial Hospital,
- St Mary's Hospital,
- Petersfield Hospital.

Population served:

- Portsmouth Hospital NHS Trust is located in Cosham, Portsmouth and is a 1200 bedded District General Hospital providing a comprehensive range of acute and specialist services to a local population of approximately 208,900 people.
- The trust provides specialist renal services to a population of 2.2 million people across Wessex.
- According to 2011 census, the ethnic breakdown of Portsmouth's population is as follows: 84.0% White British, 3.8% Other White, 1.3% Chinese, 1.4% Indian, 0.5% Mixed-Race, 1.8% Bangladeshi, 0.5% Other ethnic group, 1.4% Black African, 0.5% White Irish, 1.3% Other Asian, 0.3% Pakistani, 0.3% Black Caribbean and 0.1% Other Black.

Health Profile and Deprivation:

- The health of people in Portsmouth is generally worse, than the England average. Deprivation is higher than average and about 25.2% (9,000) children live in poverty.
- Life expectancy for men is lower than the England average.
- Levels of teenage pregnancy, GCSE attainment and smoking at time of delivery are worse than the England average.
- In 2012, 25.1% of adults are classified as obese.
- The rate of alcohol related harm hospital stays represents 1,139 stays per year.
- The rate of self-harm hospital stays represents 654 stays per year, worse than the average for England.
- Almost half of all the deaths in Portsmouth are caused by heart disease, stroke, cancers and respiratory conditions.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Leanne Wilson, Interim Head of Hospital inspections, Care Quality Commission

The inspection team consisted of two CQC Heads of Inspection, three CQC inspectors, one mental health act

reviewer and two Inspection Managers. We were supported by a variety of specialists including, a chief executive, a director of nursing, medical director, HR Director, and governance specialists.

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?

Summary of findings

- Is it well-led?

The unannounced inspection took place on 16, 17 and 28 February 2017 and looked at the urgent and emergency service and medical care (including older people's care) service. The announced focused inspection took place on 10 and 11 May 2017 and focused on the key question of 'well led' at provider level.

Before visiting, we reviewed a range of information we held, from organisations on what they knew about the hospital. These included the clinical commissioning group (CCG); NHS England; Health Education England (HEE); General Medical Council (GMC).

During our inspections we spoke with a range of staff in the hospital, including nurses, junior doctors,

consultants, administrative and clerical staff. We also spoke with the executive leaders of the trust as well as staff in support functions including governance and complaints. We also spoke with the trust's freedom to speak up guardian.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

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 Queen Alexandra Hospital NHS Trust.

What people who use the trust's services say

Results from the CQC in-patient survey from June 2016 showed the trust is performing about the same as other trusts for all of the indicators.

The trust's friends and family test results showed that of the percentage of patients who recommend the service, that overall the trust scored an average of 96% between November 2016 and February 2017. This was above the England average of 95%.

For areas which were the focus of our inspection:

- Urgent and emergency care the results between November 2016 and March 2017 showed that on average 93% of people would recommend the A&E service to friends and family. This was above the England average of 87%.

For Medical care areas we visited the majority of areas showed results above the England average. However the areas where concerns were noted were:

- Acute Medical Unit scored between 86% and 90% during this period.
- Ward C5 scored between 86% and 96% during this period.
- Ward D2 scored between 91% and 93% during this period.
- Ward F3 scored between 21% and 67% during this period.

Facts and data about this trust

- This organisation has four locations.
- There are approximately 975 beds in the trust, the majority of which are general beds.
- The trust serves a population of approximately 610,000 people from Portsmouth.
- The renal centre provides services to 2.2 million people.
- The trust employs 6,300 staff (WTE).
- There were approximately 132,000 A&E attendances, over 55,000 inpatient admissions. There were 6,300 births between April 2015 and March 2016.
- There was one mortality outlier in this trust. This related to 'pleurisy, pneumothorax, pulmonary collapse'.

Summary of findings

- For the 12-month period from Oct 15 - Sep 16, HSMR was higher than expected with a value of 111.42. Performance had declined compared to the previous year.
- SHMI for July 2015 to June 2016 was 110.77 which although above the national average is within control limits.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We have not rated safe because this was a focused inspection undertaken in response to concerns. We found:</p> <ul style="list-style-type: none">• We identified 24 incidents which had been incorrectly graded with 'low harm'. For example, a misdiagnosed fracture was graded as 'low harm'.• The quality of how Duty of Candour was undertaken was variable.• We were not assured the training met the requirements of level two safeguarding for adults.• The quality of root cause analysis investigations was variable with many being poorly investigated and completed.• We were concerned by the high prevalence of safeguarding events being reported and investigated. In some of these cases we were not assured that appropriate investigation or actions to protect other patients from the risk of harm had taken place.• There was a lack of ownership, oversight and lack of risk management regarding patients in the hospital with a mental health condition.• There was no protocol for the safe clinical management of patients awaiting admission in the waiting room, or how to escalate concerns regarding crowding or patient safety in this area <p>However:</p> <ul style="list-style-type: none">• The named safeguarding adult nurse for the trust is 'PREVENT' trained.• There were clear protocols and pathways in place for recognising and managing female genital mutilation (FGM). <p>Duty of Candour</p> <ul style="list-style-type: none">• The trust's Duty of Candour policy was out of date, dated for review in January 2017. The policy definitions of what constituted harm was not in accordance with the definition from the National Patient Safety Agency 'Seven steps to patient safety' tool.• Staff were aware of duty of candour, which ensured that patients and/or their relatives were informed of incidents which had affected their care and treatment and were given an apology.	<p>Not sufficient evidence to rate ●</p>

Summary of findings

- We were provided with examples of where duty of candour had been applied. These were also recorded in the incident investigation record if the event was more serious.
- The quality of how Duty of Candour was undertaken was variable. We saw in two cases the family were informed of the investigation at the time they were informed their relative had died. The letters did not detail what Duty of Candour meant and what the investigation would entail.
- We reviewed 350 incidents selected at random reported by the trust between February and April 2017. Of those we found that Duty of Candour or being open was not recorded as being undertaken for 24 (7%) incidents when the type of incident required it.
- In one case, a patient who unexpectedly went into cardiac arrest was resuscitated due to staff not having access to the notes which contained a DNACPR. There is no evidence on the incident report that Duty of Candour or being open was undertaken to the next of kin regarding the resuscitation.
- In a second case an incident recorded that 'This could have an impact on [their] mental wellbeing for, possibly, a long time'. There was no evidence on the incident record that duty of candour or being open was undertaken.
- In a third case of a patient receiving palliative care being required to have a further CT scan reportedly caused distress to the patient and her family prior to the patient's death. This incident was graded as a 'low harm', despite the psychological trauma experienced. There was no evidence on the incident record that duty of candour had been completed.

Incidents

- We reviewed incidents reported prior to the inspection. These demonstrated that the level of harm a patient experienced as a result of an incident was not always correctly graded.
- We reviewed a selection of 350 incidents reported between 01 February 2017 and 30 April 2017. We found that some incidents reviewed were categorised incorrectly. For example, 'consent, communication, confidentiality' when it related to failure to recognise a deteriorating patient, and a grade three pressure ulcer recorded as a records issue.
- We identified 24 incidents which had been incorrectly graded with 'low harm'. For example a misdiagnosed fracture was graded as 'low harm', a missed tendon injury was graded as 'low harm'.
- Another incident related to a missed cervical spine event, with delay in identification of the issue and treatment required of four hours. The patient was moved between departments

Summary of findings

during this time without the cervical spine being secured. The patient had progressive changes in how much they could move their limbs during this time. The incident recorded as a 'low harm' with an investigation outcome of 'Anything done differently would not have made any difference to this patient outcome'. However this outcome had not been confirmed through a thorough serious incident investigation.

- A patient arrested following a catastrophic bleed. The suction in the bed space and the next bed space were not assembled correctly and therefore did not work thus preventing airway management. This was graded as a low impact. The impact of not having functioning equipment to treat the patient was not detailed on the incident investigation.
- We reviewed eight root cause analysis investigation reports that had been signed off as completed. The quality of these investigations was variable with many being poorly investigated and completed. The terms of reference for investigation often did not cover the broad scope of issues related to the incident. The terms were generic and pre-populated in each report reviewed.
- The root cause analysis investigations were not always completed to a good standard. The identification of care and service delivery problems, as well as understanding the root cause of an incident was poor. For example in a case of a patient deterioration resulting in the patient death three care problems were identified. The lessons learned were minimal and did not cover the range of care issues identified. The investigation outcome stated, 'It is the view of the report authors that the lack of escalation of the EWS score had no impact on the eventual outcome'. This was written despite the range of failings to this patient's care.
- There was limited assurance that staff completing investigations were trained in root cause analysis investigation. There was no evidence available which demonstrated what training the panel members, who signed off the final reports, had received.

Safeguarding and Mental Health

- Safeguarding adults training was provided across the trust. On review of the content of the safeguarding adult training we were not assured the training met the requirements of level two safeguarding for adults, as described by the 'Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document'. In addition medical staff at consultant grade within the trust have not all been trained to level three as required by the intercollegiate document.

Summary of findings

- There was a policy and procedure for the safeguarding of vulnerable adults in the trust. We were not assured that all elements of this policy were being adhered to.
- The incident reporting processes in the trust was not capturing all potential safeguarding concerns. For example, one incident reported was classified as, 'Access, admission, transfer, discharge (including missing patient)'. The incident related to a case of suspected financial abuse towards a vulnerable patient. This was graded as a low impact and there was no evidence on the incident record of safeguarding input, an alert being raised, follow up or outcome.
- Through conversations with external stakeholders regarding safeguarding reporting, investigation and processes significant concerns were raised to us regarding the trust's safeguarding practices.
- We were concerned by the high prevalence of safeguarding events being reported and investigated. At the time of the inspection there were three serious allegations of physical abuse between staff and patients under investigation by the police and local authority. There were three cases of where a patient with a learning disability had died as a result of poor care, documentation and decision making. These were going through a serious case review at the time of our inspection. There was a case subject to police investigation in relation to wilful neglect of patient care.
- In some of these cases we were not assured that appropriate investigation or actions to protect other patients from the risk of harm had taken place. This concern was also shared by external stakeholders.
- Following our February 2017 inspection we asked for safeguarding concerns to be raised to the local authority on three patients whose care we witnessed constituted a safeguarding investigation. We were provided with no assurances that the trust reported these concerns to the local authority.
- During our May 2017 inspection we asked for formal confirmation that safeguarding concerns were raised to the local authority in respect of four patients we observed. We received confirmation that these cases were reported.
- We were not assured that the processes for safeguarding children were effective within the emergency department. We were informed of two cases that occurred in the week prior to our inspection where children under the age of one year old were sent home despite bruising of unknown origin being found.

Summary of findings

- The ‘Protocol for the management of actual or suspected bruising in infants who are not independently mobile’, states, ‘This protocol must be followed in all situations where an actual or suspected bruise is noted in an infant who is not independently mobile’. However, on discussion with the safeguarding team they informed us that the bruises were “open to interpretation” by the medical staff. Therefore we were not assured that the protocol was being adhered to.
- Concerns were raised through a serious case review regarding the trust’s processes for identification and management of domestic abuse cases. The outcome of the case identified failings from the trust to protect the woman. A repeat audit undertaken showed that domestic violence knowledge amongst staff was still limited, and further work was needed to improve this.
- Following our inspection in February 2017 the trust produced a training needs analysis for mental health training. The needs analysis did not identify the correct training needs and subsequently meant that when we returned in May 2017 staff were still not sufficiently trained in mental health awareness. This was evidenced by a lack of knowledge on how to care for patients with a mental health concern or learn from incidents.
- There had been a suicide in December 2016 of an individual who had left the emergency decision unit whilst awaiting an assessment by the mental health liaison team. The patient was considered to be high risk of suicide and was reported in the Serious Incident Requiring Investigation (SIRI) report. Although there were clear potential opportunities for learning, the SIRI report identified no care or service delivery problems.
- We reviewed medical records for a non-detained patient and found their record showed they were high risk to self and potentially others. According to their notes, they had been admitted to the unit following a self-harm event. The patient was awaiting an assessment by the mental health liaison team through referral to another trust. On reviewing the patient record, inspectors observed there was no care plan in place to manage the patient’s risks to self or others whilst the patient awaited review by the mental health liaison team. We later identified that the patient had left the ward without challenge, and staff were not aware of the patient’s whereabouts.
- Staff in frontline areas were offered training in safe breakaway techniques. However, this training was not considered mandatory for frontline staff, and, as such, could not provide assurance of staff safety in the event they needed to safely

Summary of findings

remove themselves from a volatile situation. This may also have presented a risk to patients as staff may cause injury if attempting to breakaway without appropriate training. The course had not been attended by medical or clerical staff.

- We reviewed four sets of clinical records of patients with mental health conditions. Three out of four patients did not have a risk assessment or corresponding care plan detailing interventions required to maintain the safety and wellbeing of the patients whilst in their care.
- There were no local audits undertaken for quality in safeguarding. The only audit completed was the nationally required section 11 audit.
- The named safeguarding adult nurse for the trust is 'PREVENT' trained. The PREVENT duty's aim is to help stop vulnerable people from being exploited and drawn into terrorism.
- There were clear protocols and pathways in place for recognising and managing female genital mutilation (FGM).

Assessing and responding to patient risk

- During our February 2017 inspection there was no protocol for the safe clinical management of patients awaiting admission in the waiting room, or how to escalate concerns regarding crowding or patient safety in this area. A direct access for GP Heralded Patients to AMU standard operating procedure was provided to the CQC in March.
- To ensure that there was an effective system in place to ensure that the treatment provided to patients being treated in the Acute Medical Unit at Queen Alexandra Hospital protects them from the risk of harm we took urgent action to impose conditions on the trust's registration in respect of the Acute Medical Unit. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we did not do so.
- The trust consistently has high reported numbers of 12 hour Decision to Admit (DTA) trolley breaches. In February 2017 there were 87 and 95 in March. There was no clear plan to address the significant capacity issues causing crowding in the emergency departments in the short or medium term. Delayed care and breaches of the four hour timeframe and 12 hour trolley breaches appeared to be normalised.
- Medical staff from specialties were not fully engaged to support the acute medical model, this meant that there often delays to see a consultant or senior member of medical staff. In some cases this could be several days. This could place patients at risk of harm.

Summary of findings

- We attended bed meetings and observed flow. We found that the level of consideration to be given on where a patient was to be placed was not sufficient and inconsistent between shifts. Through data analysis we identified two incidents where patients on wards, outside of their specialist condition, died due to staff not recognising their specialist needs.
- Radiology as a service have placed on their risk register the lack of capacity in the service to report on chest x-rays. The decision was taken not to report on any chest x-rays within radiology. Review of chest x-rays is being undertaken by medical staff of all grades and not qualified radiology staff. Radiology compliance against local procedures is low and that over 40% of x-rays that are taken do not have an associated clinical evaluation. The trust has a policy that states if a formal report is required then they will provide one but if a suspicious lesion is not seen in the first instance this process would not be triggered. The Trust has accepted this risk with no associated action plan in place to mitigate the risks to patients. Therefore patients are at risk of harm through limited diagnostic assurance on diagnosis.

Are services at this trust effective?

We have not rated effective because this was a focused inspection undertaken in response to concerns. We found:

- We found examples during this inspection that not all staff complied with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards.
- We found patients who had procedures undertaken on them without appropriate best interest decision or mental capacity assessments being conducted for consent.
- Understanding of Derivation of Liberty Safeguards (DoLS) was inconsistent across the areas we inspected. We found four cases of DoLS being used on patients without appropriate authority being given by the local authority, and no paper work completed.
- The understanding of use of chemical restraint on patients was poor.

However:

- Most specialties provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines.

Evidence based care and treatment

Not sufficient evidence to rate



Summary of findings

- Most specialties provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included stroke pathways, sepsis, acute kidney injury, non invasive ventilation and falls.
- During 2015/2016, 38 national clinical audits and 8 national confidential enquiries covered NHS services that Portsmouth Hospitals NHS Trust provides. During that period Portsmouth Hospitals NHS Trust participated in 97% (37/38) national clinical audits and 100% (8/8) national confidential enquiries of those it was eligible to participate in.
- During 2015/2016, Portsmouth Hospitals NHS Trust has participated in a total of 316 clinical research studies, 84% of these studies were NIHR Portfolio adopted.

Patient outcomes

- A self-assessment of the emergency department against the 5 NICE guidelines relating to Major Trauma, in February 2016, showed the service was compliant at: 98% for complex fractures (NG37), 91% for non-complex fractures (NG38), 96% on assessment and initial management (NG39), 93% on service delivery (NG40).
- The Patient Reported Outcome Measures (PROMs) finalised (EQ5D Index) report for 2015/16 showed the trust performed better than the England average on groin hernia, but worse than average on hip replacement surgery, varicose vein surgery and knee replacement surgery.
- The percentage of patients to be re-admitted within 28 days of being discharged was better than the England average (10.8% against 11.4%) for patients over 16 years of age. However the percentage was worse for patients under 16 years (12% against the average of 10%).

Competent staff

- We identified that the process for the induction of agency nurses was not effective. This was because the process for formal checks on the nursing competencies for the administration of IV fluids on the wards was inconsistent. This placed patients at the risk of harm without sufficient evidence to demonstrate staff are competent to administer IV's.
- There were general concerns regarding some competencies for clinical experience and use of equipment in areas including theatres, the emergency department and the wards.

Summary of findings

- We were concerned that the emergency department medical staff were working outside the scope of their clinical skills and competencies. The emergency department staff were providing acute medical care to patients due to the medical staff not willing to take medical patients outside of their specialist area. This placed the emergency medical doctors at risk.

Multidisciplinary working

- Wards teams had access to the full range of allied health professionals. Staff from various teams who spoke with us described good, collaborative working practices. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.
- This was not the case for the medical services, where concerns were raised to us regarding joint working in medicine. This predominantly linked to the work across the acute medical pathways.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- We found examples during this inspection that not all staff on the emergency decision unit, ward C5 and ward F2 complied with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards. Understanding of Derivation of Liberty Safeguards (DoLS) was inconsistent across the areas we inspected. We found four cases of DoLS being used on patients without appropriate authority being given by the local authority, and no paper work completed.
- One patient on AMU had a known mental health concern and was left unobserved on the ward. The patient was recorded as being at risk of suicide, yet was identified as fit to leave the department.
- We found that two patients had procedures undertaken on them without appropriate best interest decision or mental capacity assessments being conducted.
- The understanding of use of chemical restraint on patients was poor. We identified three cases of where chemical restraint was used on a patient without appropriate paper work being completed to authorise this as being in the patient's best interests.
- Since our inspection in February 2017, the trust had produced a guide for staff on the covert administration of medicines. This

Summary of findings

guide was not appropriate in its style. The images used on the guide were pictures were not appropriate and could be misinterpreted. For example, next to the word covert there was a picture of a detective.

- In the trust private board minutes from March 2017 the covert administration of medicines was discussed. It was noted that the medical director stated that it was essential that the full and appropriate paperwork was kept to demonstrate the thought processes behind the decision to administer medications appropriately. These included best interested meeting and Deprivation of Liberty Safeguards (if appropriate) It was recorded that the medical director said, 'this becomes more of a problem the longer the patient remains on the unit'.

Are services at this trust caring?

We have not rated caring because this was a focused inspection undertaken in response to concerns.

We found:

- We observed that staff did not always provide compassionate care to patients and did not always respond to patients when they called out for assistance. For example on AMU a member of staff stood next to the patient did not respond to these calls, and as a result the patient was incontinent.
- We observed situations where vulnerable patients were at risk of harm and the inspection team had to request staff intervene to maintain the patients' safety.
- Staff did not always protect patients' dignity and did not always keep personal information about patients confidential.
- Results of the friends and family test for some medical areas were consistently low.

However:

- Across the emergency department and wards patients were mostly happy with the care they were receiving.
- Results from the CQC in-patient survey from June 2016 showed the trust is performing about the same as other trusts for all of the indicators.
- The trust's friends and family test results showed that of the percentage of patients who recommend the service, that overall the trust scored an average of 96% between November 2016 and February 2017. This was above the England average of 95%.

Compassionate care

Not sufficient evidence to rate



Summary of findings

- Across the emergency department and wards patients were mostly happy with the care they were receiving.
- However we observed that staff did not always provide compassionate care to patients and did not always respond to patients when they called out for assistance. We observed situations where vulnerable patients were at risk of harm and the inspection team had to request staff intervene to maintain the patients' safety.
- For example on AMU a member of staff stood next to the patient did not respond to these calls, and as a result the patient was incontinent.
- Staff did not always protect patients' dignity and did not always keep personal information about patients confidential.

Understanding and involvement of patients and those close to them

- Results from the CQC in-patient survey from June 2016 showed the trust is performing about the same as other trusts for all of the indicators.
- The trust's friends and family test results showed that of the percentage of patients who recommend the service, that overall the trust scored an average of 96% between November 2016 and February 2017. This was above the England average of 95%.
- For areas, which were the focus of our inspection, urgent and emergency care results showed that on average 93% of people, would recommend the A&E service to friends and family. This was above the England average of 87%.
- For Medical care areas we visited the majority of areas showed results above the England average. However the wards where concerns were noted were the Acute Medical Unit (86%-90%), ward C5 (86% and 96%), ward D2 (91% and 93%), and ward F3 (21% and 67%) during the period of November 2016 and March 2017.

Emotional support

- At the previous inspection in September 2016 we found patients and their representatives were not involved in planning and making decisions about their care and treatment. Following the inspection, the trust was issued with a requirement notice with regard to the regulation concerning person centred care. This required the trust to submit an action plan detailing how they planned to address the concerns raised

Summary of findings

in our inspection report. The trust submitted an action plan stating they would revise nursing documentation to re-enforce registered nurses to sign that the patient and/or their representative had been involved in their care planning.

- The documentation audit for February 2017 submitted by the trust showed out of 30 patients on medicine wards only 27% had their care record discussed with them or a relative. We reviewed 22 patient's medical records and none of them had evidence the patient or their family had been involved in their care planning.

Are services at this trust responsive?

We have not rated responsive because this was a focused inspection undertaken in response to concerns. We found:

- There were no mitigations in place at the time of our inspection should the new medical model not work, which meant that the trust was in an unsafe position with the emergency department doctors caring for medical patients.
- Trust performance for average length of stay for non-elective admissions was generally worse than the England average.
- The trust had a backlog of complaints through the CSC's, which did not appear to have priority focus. In some cases patients were waiting several months for a response to their initial complaint.
- We were not assured that learning from complaints was shared across the CSC's

However:

- There was an improved and dedicated focus to providing care to patients with a learning disability.
- There was trustwide access to language line and translation services for those whose first language was not English.
- Dementia formed part of the quality objectives for the trust. There were provisions in place to support someone living Dementia. This included staff training, and the use of dementia champions in the hospital.

Service planning and delivery to meet the needs of local people

- The emergency department staff were providing acute medical care to patients due to the medical staff not willing to take medical patients outside of their specialist area. This placed the emergency medical doctors at risk, and could also affect training placements for emergency medical trainees in the department.

Not sufficient evidence to rate



Summary of findings

- We were informed during an engagement meeting with the trust in December 2016 that the job plans for the medical staff were reviewed and medical staff would soon start to care for medical patients on the acute care pathway, that were outside of their specialty. Despite these assurances, during our inspection we found this not to be the case. The medical model for acute care was to be launched on 08 May 2017 yet the doctors refused to take part in caring for patients on the pathway.
- There were no mitigations in place at the time of our inspection should the new model not work, which meant that the trust was in an unsafe position with the emergency department doctors caring for medical patients. There were no clear lines of accountability for the acute pathway.
- Stakeholders were aware of the new model being launched, however the trust failed to communicate with them in a timely manner that this launch had failed, or that additional support was required.

Meeting people's individual needs

- Prior to our inspection we were alerted to concerns regarding the care for patients with learning disabilities. There was a two year gap in the provision of learning disability care across Hampshire. During this time there were three incidents involving patients with a learning disability. The care of those patients was found to be substandard and the cases have gone to a serious case review.
- Within the last six months the contract has been recommissioned, and the service provision for patients with a learning disability is now fully established. The processes observed during the inspection demonstrated that there were now effective measures in place to support patients with a learning disability requiring care. We observed that there was a dedicated focus to the learning disability patient group, who were actively seeking to learn the lessons from the incidents and improve the service for patients.
- There was trustwide access to language line and translation services for those whose first language was not English.
- Dementia formed part of the quality objectives for the trust. There were provisions in place to support someone living Dementia. This included staff training, and the use of dementia champions in the hospital.

Access and flow

Summary of findings

- There were significant concerns with flow through the hospital. Due to the flow issues the acute medical unit, where patients would normally stay for 72 hours, was being used as a short stay ward. The acute medical unit function was predominantly in the main majors area of the emergency department.
- There were significant challenges with flow throughout the hospital. There was a normalised focus to the number of patients who were medically fit for discharge. This was partly impacted by challenges within the wider Hampshire system, however the normalised approach meant that length of stay was longer than expected. For example, during the inspection of their 1050 acute beds there were 253 patients medically fit for discharge.
- Concerns were raised to us regarding the new discharge service introduced at Queen Alexandra Hospital which staff felt was making the discharge process slower, and increasing length of stay.
- We reviewed the acute medical pathway and data on flow in response to this. Between April 2016 and March 2017, the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was 39%. This was against the national average of 12%.
- Trust performance for average length of stay for non-elective admissions was generally worse than the England average. Cardiology showed a slightly better average length of stay than the England average.
- The ambulance service within the region is also significantly impacted by the flow through the Queen Alexandra Hospital. Of all hospitals across south central England the Queen Alexandra Hospital is consistently the trust that loses them the most hours on the road.

Learning from complaints and concerns

- The trust board received data about complaints and complaints were discussed at the local governance and audit meetings. All complaints were seen and signed off by the interim Chief Executive Officer (CEO).
- Literature and posters were displayed within the wards, advising patients and their relatives how they could raise a concern or complaint, both formally and informally. This literature was available in other languages besides English.
- Although staff told us that learning from complaints took place at a ward level, we were not assured that learning from complaints was shared across the CSC's.

Summary of findings

- We discussed learning from complaints with the complaints team and found that the processes and policies for complaints were there. However, they were not effective in practice.
- For example, complaints should be responded to in a timeframe set within the trust policy. The trust had a backlog of complaints through the CSC's, which did not appear to have priority focus. There was also no highlighting of the backlogged reports to the board for executive oversight. In some cases patients were waiting several months for a response to their initial complaint.
- The way in which responses to complaints and concerns were handled by the trust was not consistent. Some poorly investigated and non-supportive responses were being issued by the trust. This resulted in further complaints being raised about the complaints process. This was supported by a number of concerns coming to CQC about the quality of their complaint response, and length of time taken to respond to a complaint.
- The Parliamentary Health Service Ombudsman had 11 open cases with the trust. The trust felt this reasonable given their overall complaint numbers. The outcomes of these cases were not yet known.

Are services at this trust well-led?

We have not rated well led because this was a focused inspection undertaken in response to concerns.

We found:

- The uncertainty around leadership and the various changes had created a feeling of instability within the trust and meant that the direction and leadership approach to the organisation was not clear.
- There were no clear lines of accountability for the acute pathway. This meant that no executive member of the trust was taking responsibility for the acute pathway.
- There were no mitigations in place at the time of our inspection should the new model not work, which meant that the trust was in an unsafe position with the emergency department doctors caring for medical patients.
- There was a culture of 'specialism' within the trust. The trust was largely focused on their specialist services and provisions that the main district general hospital areas such as general medicine were forgotten.
- We were not assured that the processes for raising concerns internally were open and free from blame. This discouraged staff from feeling free to speak about concerns.

Not sufficient evidence to rate



Summary of findings

- Staff perceived there was bullying and did not feel able to speak out about concerns. Examples were given to us of how staff became unwell through stress and anxiety about these concerns.
- The culture amongst medical staff has been identified as a concern by unions and other stakeholders.

However:

- The trust had a defined process for fit and proper person's employed.
- Many staff reported good experience of culture and openness within their local departments.
- The trust had defined policies and process for the fair and equal treatment of all staff in employment. Consideration was given to WRES as part of recruitment, and education opportunities within the trust.
- We reviewed the trust's policies and processes for raising concerns, and found that there was an expansive range of options available for staff to speak openly about any concerns they may have.
- The NHS staff survey was in line with the England average.

Leadership of the trust

- The senior team were made up of mainly Interim leaders. The Chief Executive, Chief Operating Officer, Director of Nursing, and Director of Human Resources were all interim. The Medical Director was due to retire, and the Chair was scheduled to end their term in June 2017. Recruitment for all of these posts was underway at the time of our inspection.
- The uncertainty around leadership and the various changes had created a feeling of instability within the trust and meant that the direction and leadership approach to the organisation was not clear.
- The Non-Executive Directors mostly had backgrounds unrelated to healthcare. Through review of the minutes of board minutes there was little recorded challenge by the non-executive directors. The Chief Executive informed us that two new Non-Executive Directors had recently joined, and were providing a higher level of useful challenge, which the board found useful.
- We were not assured following our interviews with the trust board members that the team were cohesive and had sufficient skill set to be able to understand the tasks ahead, the risks they faced and could articulate a way of driving delivery at a pace that would show improvements to patient care.

Summary of findings

- We were informed during an engagement meeting in December 2016 that the job plans for the medical staff were reviewed and medical staff would soon start to care for medical patients on the acute care pathway, that were outside of their specialty. Despite these assurances, during our inspection we found this not to be the case. The medical model for acute care was to be launched on 08 May 2017 yet some doctors refused to take part in caring for patients on the pathway. A letter was subsequently sent on 31st May 2017 to all in scope consultants to secure their agreement to the change in job plan.
- There were insufficient mitigations in place at the time of our inspection should the new model not work. This meant that the trust was in an unsafe position as emergency department doctors were caring for medical patients for extended periods of time.
- There was lack of clarity around the lines of accountability for the acute pathway. This meant that no executive member of the trust was taking responsibility for the acute pathway. Neither the Medical Director nor the Director of Unscheduled Care felt this was an issue or had any plans to direct the medics to look after these patients after decision to admit. This placed patients at risk of harm.
- We were significantly concerned about the lack of oversight on safeguarding matters and mental health care within the trust at senior management and executive board level.

Culture within the trust

- There was a culture of 'specialism' within the trust. The trust was largely focused on their specialist services and provisions that the main district general hospital areas such as general medicine were forgotten. We discussed this with the Interim Chief Executive who agreed that there was a culture where specialist services held greater priority over core District General Hospital services and that this was a challenge that needed to be addressed.
- During the inspection we held drop in events and received communications from staff who worked at the trust. Many staff reported good experience of culture and openness within their local departments. However we received several concerns from staff cross the medical, emergency and surgical areas.
- Prior to this inspection we received four qualifying whistleblowing concerns and more than fifteen separate concerns. Staff perceived there was bullying and did not feel able to speak out about concerns.

Summary of findings

- We reviewed the trust’s policies and processes for raising concerns, and found that there was an expansive range of options available for staff to speak openly about any concerns they may have.
- We were not assured that the processes for raising concerns internally were open and free from blame. We reviewed case examples of how staff had been treated or supported when concerns were raised. This included staff being excluded or isolated from their work for raising concerns regarding patient safety. This discouraged staff from feeling free to speak about concerns.
- Staff provided statements of their conversations and interviews with leaders of local CSC’s and executive directors that made them feel not listened to, not supported, and they perceived this as a form of bullying. One staff member spoke of their treatment to us and was extremely anxious about the impact of raising concerns to us..
- In pathology, concerns were raised to us by staff who felt the culture in cancer pathology laboratory is “corrupt – not open and transparent”. They felt there was a culture of “covering things up” and staff were being told not to speak out.
- We spoke with the trust’s freedom to speak up guardian, who was unclear about the role and remit of a guardian. When asked about the concerns raised by CQC to the trust on behalf of staff they informed us they were not aware of this. This meant we were not assured concerns on behalf of staff were being shared with the trust guardian.
- Unions including the British Medical Association, and organisations including Health Education England and the GMC also raised concerns with us regarding the culture of the organisation. They believed that there continues to be a culture of bullying and harassment in specific areas within the organisation.
- During our conversations with staff we provided support and guidance on how to seek support and protection during this time. One staff member went to the BMA with their concerns and was advised not to raise concerns due to whistleblowers being targeted in the NHS.
- When we approached the BMA about this, they were aware of concerns in relation to the trust that had been raised by doctors previously.
- The culture of medical staff throughout the medical division and unscheduled care was of significant concern to us. We

Summary of findings

found that there was a culture that was not supportive to patient safety, quality or care to those requiring general medical admission or treatment. This resulted in delays for patients to receive medical care.

- In other areas such as paediatrics, maternity and critical care staff provided good examples of how leadership and culture was positive in their areas. This included being open and raising concerns.
- Whilst there was a process for being open and meeting the Duty of Candour requirements, no quality audits were undertaken to assess how open and transparent the trust was to patients, families and carers.
- Portsmouth Hospitals NHS Trust had 3949 staff take part in the national staff survey. This is a response rate of 58%, which was in the highest 20% of acute trusts in England.
- The trust returned 19 positive, six similar to expected and seven negative findings from 32 questions in the 2016 staff survey, placing it in line with other trusts across England.

Vision and strategy

- The trust did not have a current vision or strategy. We were informed that this was due to the changes amongst the leadership team but that there were plans to review the strategy in the near future.

Governance, risk management and quality measurement

- The governance system within the trust was not fit for purpose and required immediate review to ensure that risks are identified, monitored and managed appropriately. There was a disconnect between the CSC's and the senior leadership team particularly in relation to governance and risk management.
- The trust is quick to react when a concern is raised with them by the regulators to resolve the issues raised. However the trust cannot prove a track record of sustained improvements across all areas. For example in February 2017 the Care Quality Commission identified significant concerns regarding safeguarding, and care for patients with mental health conditions in the emergency department. We raised this with the trust who provided assurances that the concerns had been addressed and that patients were safe. However, when we returned in May 2017 the improvements had not been sustained and CQC was required to take urgent action because we believed a person will or may be exposed to the risk of harm if we did not do so. The assurances provided by the trust in this case had not been sustained.

Summary of findings

- In the 2015/16 quality account report the trust identified a priority to 'Improve experience for patients with mental health needs' with a target date of 2016. This has not been delivered due to the significant concerns regarding mental health identified during the inspection that resulted in immediate enforcement action being taken.
- The quality account objectives were not reflective of what was discussed during board meetings. For example mental health care, learning disability care or safeguarding were not routinely discussed by the board. Therefore we were not assured that the quality account objectives were being monitored or achieved.
- The private board papers, in the majority, should have been shared in public board. Not sharing information on complaints, incidents and mortality publicly did not demonstrate an open and transparent approach from the trust.
- Radiology as a service have placed on their risk register the lack of capacity in the service to report on chest x-rays. The decision was taken not to report on any chest x-rays within radiology. The Trust has accepted this risk with no associated action plan in place to mitigate the risks to patients. Without any quality monitoring or audits on risk management of this process, this identifies poor governance with radiology processes in the trust.
- The trust board assurance framework is reviewed at every board meeting. The board assurance framework from May 2017 did not cover the top risks for the trusts. This included the risks identified during the inspection regarding mental health, safeguarding and the acute medical model.
- We discussed the quality of the board meeting minutes, and the approval process with the Chief Executive. The minutes are distributed and checked for accuracy at each meeting. The Chief Executive acknowledged that the minutes were minuted in a way which may not always provide a clear understanding or reflection of the discussion. For example, comments on mortality being caused by 'patients remaining in hospital for too long' are not appropriate for recording without full context behind such statements being included in the minutes.
- The governance processes to get reports to the board, and how committees and meetings feed into the board framework was disjointed. The misalignment of governance functions enabled key risks to go unidentified and unsighted by the trust board. The framework for escalating risk management matters through the governance process required review. For example safeguarding was rarely discussed at board level, despite concerns raised through CQC inspections over the previous few months.

Summary of findings

- The board meetings held were not always attended by key members of the trust board, which means that consideration should have been given to cancelling the meeting. For example at the board meeting on 2 February 2017 the board meeting was not attended by the chairman or two non-executive directors.

Mortality and Morbidity

- For the 12-month period from Oct 15 - Sep 16, HSMR was higher than expected with a value of 111.42. The SHMI for July 2015 to June 2016 was 111, which although above the national average of 100 was within control limits.
- There was no assurance that the trust had considered or undertaken harm reviews for patients whose care was delayed through the acute care pathway.
- Mortality has increased at a steady rate over the last 12 months, and we were not assured this was being addressed. We were informed that mortality was high due to the 'unscheduled care pathway'. However no audits or evidence had been gathered to support this statement's accuracy. Since the inspection, the trust has provided information which demonstrates they are working to improve their processes for monitoring mortality.
- Mortality reviews were not taking place in a detailed way in every CSC. The trust was rolling out a mortality review panel as an independent process by specialty. The Medical Director chose an independent panel approach to potentially avoid any bias that may occur within the divisions.
- The trust board were sighted on mortality through regular reports. We were not assured that the gravitas of a steadily increasing mortality were fully understood; however, the minutes of the board meeting held in April 2017 said, 'The Chairman recognised the negative effect on the HSMR of patients remaining in hospital for too long'."
- The trust had one mortality outlier alert related to 'pleurisy, pneumothorax, pulmonary collapse'. The trust's response to CQC did not address the key issues regarding the quality of how the mortality review was undertaken. After our inspection the trust provided the CQC with an action plan which had been developed to address areas for improvement identified by the trust. The trust have been asked to provide CQC with further information on this mortality outlier for consideration.

Coroners Correspondence

- We reviewed three regulation 28 notices from the coroner. These are served for the purpose of preventing future deaths.

Summary of findings

- We received coroner correspondence with concerns regarding the records presented to inquest being 'materially different' to those held by the family. We reviewed the concerns and responded to the coroner with our concerns regarding the records accuracy within the trust. During our inspection in February 2017 it was observed that staff were entering information into patient records for care that had not been provided. We have asked for the trust to take immediate action regarding these concerns and make significant improvements regarding records entries and accuracy of the care provided.
- We reviewed a regulation 28 in respect of monitoring of INR levels amongst patients. The international normalized ratio (INR) is a standardised number that measures blood clotting factors. We reviewed the care of two patients and found that medical staff were following the trust policy on 'warfarin dosing, monitoring and reversal in adults'. Nursing staff were also observed to adhere to this policy. The records examined supported that INR levels were appropriately monitored.
- We reviewed a regulation 28 in respect of patient placement on the right specialty ward. We attended bed meetings and observed flow. We found that the level of consideration to be given on where a patient was to be placed was not sufficient and inconsistent between shifts. Through data analysis we identified two incidents where patients on wards, outside of their specialist condition, died due to staff not recognising their specialist needs.

Equalities and Diversity – including Workforce Race Equality Standard

- The trust had defined policies and process for the fair and equal treatment of all staff in employment. Consideration was given to WRES as part of recruitment, and education and equal opportunities within the trust.
- This was supported by staff survey question KF21 about equal opportunities for career progression, where the results showed higher than England average responses for both White and BME groups.
- The staff survey question KF25 on experiencing bullying and harassment by patients was higher than the national average for both white and BME staff groups. BME staff groups reported that 34% experienced this against an acute trust average of 26%.

Summary of findings

- The staff survey question KF26 on experiencing bullying and harassment by staff was in line with the national average for both white and BME staff groups. BME staff groups were reported a slightly lower rate of 24% against the national average of 27%.

Fit and Proper Persons

- The trust had a defined process for fit and proper person's employed. There was a system in place for senior staff to make a declaration of fitness. Where there are gaps in recruitment files the HR department contact the person for an explanation or to provide the appropriate documentation.
- We reviewed the files of those employed by the trust since the regulation came into force and the trust was meeting the requirements of the regulations.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- Ensure that staff are assessed and signed off as competent to deliver patient care.
- Ensure that the culture within the organisation of staff not being willing to raise concerns openly and concerns around bullying are given sufficient priority by the board.
- Review the governance functions and processes for the trust to ensure they are fit for purpose.
- Improve compliance with regulation 28 coroner reports for preventing future deaths.
- Ensure that improvements are made to the classification of incidents to ensure that they are reported, escalated and graded appropriately.
- Ensure that the conditions imposed by the Commission on the Acute Medical unit, and Emergency Department are effectively implemented.
- Improve identification and management of incidents requiring duty of candour.
- Improve the quality of Root Cause Analysis investigations.
- Review the processes for the safeguarding of vulnerable adults and children to ensure that safeguarding processes work effectively in the trust.
- Improve the processes, policies, staffing and understanding of mental health for staff at ward to board level.
- Ensure that staff have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards, and implement them effectively.
- Ensure that patients do not have procedures undertaken on them without appropriate consent being obtained, and best interest assessments are completed where applicable.
- Ensure that records completed for the purpose of care are completed accurately.
- Immediately review the risks associated with reporting of chest x-rays in radiology. Including the undertaking of a patient harm review on all cases not reported on.
- Undertake patient harm reviews and audits to identify where lessons can be learned or mortality ratios reduced.
- Immediately review the medical model within acute care to ensure that patients are seen a treating physician and treated at the earliest opportunity.
- Improve the flow and capacity throughout the hospital.
- Review the board assurance framework, board minutes, and processes for reporting at board to ensure risks are identified and managed by the trust, and that the minutes are appropriately recorded.
- Develop a vision and strategy for the trust.
- Improve the complaints processes, oversight of complaints and reduce the backlog of complaints to ensure patients receive responses in a timely way.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Section 29A HSCA Warning notice: quality of health care
The registered provider is required to make significant improvements to ensure the quality and delivery of safe care.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Section 31 HSCA Urgent procedure for suspension, variation etc.
Imposition of conditions -
The registered provider did not have an effective process in place to ensure the safety of patients during times of high capacity, crowding or demand in the Acute Medical Unit GP referral area is escalated when the need requires it. This meant that patients are placed at the risk of harm.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Section 31 HSCA Urgent procedure for suspension, variation etc.
Imposition of conditions -
We found a lack of leadership oversight of mental health provision at all levels. The processes and procedures meant that patients who were vulnerable were protected from the risk of harm. The provider had not ensured that care was being provided in accordance with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards.