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

Facts and data about this trust

The Royal Bournemouth Hospital is the larger of two hospitals provided by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The trust provides services to a population of approximately 550,000 in the Dorset, New Forest and South Wiltshire areas, which rises in the summer months due to an influx of visitors to the area.

The Royal Bournemouth Hospital has approximately 600 inpatient beds and 123 day care beds. The hospital provides urgent and emergency care, medical care, surgery, critical care, end of life care, outpatient and diagnostic services.

There is a maternity and gynaecology service, including a three bedded birthing unit and community midwife service. The children and young person’s service is limited to eye surgery and outpatients. Additionally, up to 10,000 children present to the emergency department each year.

The main centre for obstetrics and gynaecology and paediatric services is at a nearby NHS hospital provided by a neighbouring trust.

It currently has a 24-hour emergency department and a surgery admissions unit, the Sandbourne Suite. A purpose built ophthalmology unit is located on site, as well as a cardiology unit, the Dorset Heart Centre. The hospital also has an orthopaedic service providing hip and knee replacements, the Derwent Unit.
The hospital provides district-wide services for cardiac interventions, vascular surgery and urology. Outpatient clinics are provided for oral surgery, paediatrics, plastic surgery and ear, nose and throat (ENT).

The trust achieved foundation status in 2005.

Following a recent county wide clinical service review in Dorset, NHS Dorset Clinical Commissioning Group has published a plan to see the Royal Bournemouth Hospital develop as the main emergency site for residents of east Dorset (including West Hampshire and the New Forest) with the neighbouring NHS trust to become the main elective or planned care site. This is in line with the Dorset wide sustainability and transformation plan (STP), entitled ‘Our Dorset’ which sets out a five year plan to transform services across Dorset by 2020/21.

The main Clinical Commissioning Groups (CCGs) for this trust are Dorset CCG and West Hampshire CCG.

This trust is registered to provide the activities of:-

Treatment of disease disorder or injury.
Assessment or medical treatment of persons detained under the Mental Health Act 1983
Surgical procedures
Diagnostic or screening procedures.
Management of blood supply and blood derived products
Maternity and midwife services
Termination of pregnancies
Family planning
Nursing care

**Acute hospital sites at the trust**

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
</table>
| Royal Bournemouth Hospital  | Castle Lane East Bournemouth BH7 7DW | • Day surgical and short stay areas  
• Anaesthetics  
• Cardiology  
• Accident & emergency  
• General medicine  
• Geriatric medicine  
• Haematology  
• Ophthalmology  
• Trauma & orthopaedics  
• Colorectal/breast surgery  
• Vascular surgery  
• Upper GI/bariatric  
• Urology/gynaecology  
• Ambulatory emergency care  
• Antenatal and postnatal care  
• Cancer care  
• Outpatients  
• Thoracic medicine  
• Diabetes and endocrine  
• Oral surgery | • Bournemouth  
• New Forest  
• Southampton  
• Salisbury  
• Winchester  
• Christchurch and Poole |
| Christchurch Hospital | Fairmile Road Christchurch BH23 2JX | • Womens health  
• Orthopaedics  
• Pathology  
• Interventional Radiology  
• Geriatric medicine  
• Specialist palliative care  
• Specialist services  
• Outpatients  
• Pathology  
• Dermatology  
• Rheumatology  
• Bournemouth  
• New Forest  
• Southampton  
• Salisbury  
• Winchester  
• Christchurch and Poole |

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

Leadership

To write this well-led report, and rate the organisation, we interviewed both executive and non-executive directors, governors and a range of senior staff across the hospital. This included a range of clinical and non-clinical service and specialty leads. We met and talked with staff at all levels to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, strategic plans, audits and action plans, board meeting minutes and papers to the board, investigations and feedback from patients, local people and stakeholders, including NHS Improvement.

At the time of our inspection, this trust was working towards a countywide reconfiguration of services. Dorset Clinical Commissioning Group (CCG) had undertaken a wide scale Clinical Services Review (CSR) involving detailed consultation with the public and other stakeholders. The CCG published the results of the CSR in September 2017. The CSR concluded that Bournemouth Hospital would become the main emergency hospital for East Dorset with its neighbouring hospital becoming the main elective and planned care site. This represents a major step change for East Dorset as currently both hospitals provide both urgent and elective care and treatment. Additionally, the ‘Our Dorset’ sustainability and transformation plan (STP) for Dorset outlines a greater focus on illness prevention and increased community focus on managing illness. Significantly, the trust were expecting to undertake a merger with their neighbouring NHS acute trust within the next 18 months.

The trust executives presented as an exceptionally cohesive and collaborative team who were well supported, and appropriately challenged, by a range of non-executive directors (NEDs). The board demonstrated the appropriate range of skills, knowledge and experience to perform its role. The Chief Executive Officer (CEO) had been in post at the trust for 18 years so was both an experienced CEO as well as being a key part of the organisational history to date. Similarly, the Director of Nursing and Midwifery (DoN) (also the Deputy CEO) had been in post since 2011 and the Chief Operating Officer (COO) had worked at the trust since 2006, having taken the role of COO in 2014.

Following our last inspection of the trust in 2015 (report published on 25 February 2016), there had been many changes in personnel on the Board of Directors (BoD). A new Medical Director (MD) had commenced post in late 2016, a new Chairperson had started in March 2017 and a new Finance Director joined the BoD in May 2017. Both appointments had been well received by the board. The NEDs as a group were relatively new to the trust with the longest serving NED being in post since 2015. Two NEDs had been appointed in 2017 and two in 2016. The NEDs represented a broad range of leadership expertise from a diverse range of backgrounds including clinical, legal, industry and finance. We saw how this range of experience contributed to effective challenge to the executive directors. We were particularly impressed with the skill and expertise of the Independent Assurance Director who also chaired the Healthcare Assurance Committee. There was one vacant NED post at the time of our inspection and options to fill this vacancy pending the merger with the neighbouring trust were being considered by governors and the board. All of the NEDs had received training in peer review, the trust’s internal quality inspection measure, which supported them to undertake effective and consistent reviews of clinical areas.

Owing to the potential merger and the agreed reconfiguration of services, key personnel had formed the ‘One Acute Network East Reconfiguration Board’. This was a joint committee of the two boards, which was jointly chaired by both chairpersons from the two acute trusts and attended by executives and non-executives from both trusts. This programme board was overseeing the implementation of the CSR and the merger of the two trusts. It was of note that the two trusts, along with system partners, were already starting to work in a collaborative manner where practicable. For example, new public members were given the opportunity to join both acute trusts
at the same time through one membership process and some clinical services already had shared
governance in place across the two trusts.

The trust had employed a Director of Organisational Development and Leadership since 2015
(DODL). The DODL worked in conjunction with the Director of Human Resources (DoHR). The
DODL was employed for three years on a part time basis and was a non-voting director. They
were highly regarded by their peers and by staff across the trust. We heard how they had made
significant and sustained improvements in culture at the trust, ensuring that staff had meaningful
and effective ways of engaging with improvements in their everyday working life. Owing to the
DODL’s perceived success in role, the trust had agreed for them to input to the trust on a
consultancy basis once their three-year term ended, later in 2018.

Staff at all levels reported that the trust board were accessible and approachable. This was a
clear area of strength and significant improvement since our last inspection in 2015 where the
board was perceived to have been insular and somewhat hierarchical in its approach. The BoD
made clear efforts to engage with staff across the trust at every level and in all areas. Similarly,
during our last inspection in 2015 we had identified interpersonal conflicts between the trust board
and the Council of Governors (CoG). During this inspection, we met with governors who had been
on the CoG for varying times who spoke extremely positively about the current board. Governors
described feeling valued by the board who they reported were now open and transparent in their
approach. We observed governor’s attendance at the public board meeting in March 2018 where
they raised valid and pertinent challenges to the board on behalf of the public. These challenges
were accepted and actioned by relevant board members as appropriate.

The trust board held bi-annual themed meetings with the governors with focus on a particular
pertinent issue. For example, we were told the theme of the meeting in December 2017 was the
actions arising from an external well-led review of the trust. The trust also maintained a governor’s
issues log, which the governors felt assured by, as it meant their verbally reported issues, in
particular, were tracked and reviewed. Governors were offered training every other month.
Training was organised in a bespoke way to meet the needs of CoG. They reported receiving
training on a broad range of topics including making sense of financial reports, emergency
department targets and iPad training at the end of session. Each governor training event was
evaluated to ensure it was pitched at the right level and that it met the governor’s needs.

The trust was satisfied that staff with director level responsibilities, including the NEDs, were fit
and proper persons in accordance with Regulation 5 of the Health and Social Care Act 2008
(Regulated Activities) Regulations 2014. We reviewed a random sample of three board level
director’s personnel files and found that mostly all the necessary fit and proper person checks had
been undertaken. However, we found the trust had failed to carry out a Disclosure and Barring
Scheme (DBS) check on one of the non-clinical executives when they had commenced a new
appointment within the trust. This was raised with the CEO and the DoN who shared our
concerns. Shortly after our inspection, the DoN provided evidence that all other DBS checks had
been undertaken as required for all executive and non-executive directors. The DoN had also
ensured that the governance around fit and proper persons requirements and recruitment
processes were reviewed and strengthened to prevent any further gaps. We were assured by the
robust manner in which the trust responded. Throughout our inspection, we had no concerns
about the fitness of the board to undertake their respective roles.

The executive directors and the NEDs had sufficient financial expertise and consistently described
a shared understanding of the financial position of the trust and areas of opportunity.
We saw there was a robust approach to reducing inefficiencies with quality improvement
initiatives driving some areas of financial savings. The Director of Finance (DoF) sufficiently
prioritised quality care when considering cost reduction initiatives. A number of the finance team,
including the DoF, were patient meal time volunteers. This gave them an opportunity to see the
clinical services provided at first hand, build relationships with clinical staff and question inefficient
practices. Service level managers also shared a good understanding of the trust’s financial position and took financial ownership of their service.

The trust had a nominated lead for mental health. The lead chaired a steering group which was attended by internal staff involved in mental health provision and also by system partners. The trust did not directly provide specialist mental health care at either Royal Bournemouth or Christchurch Hospitals. A local community and mental health trust provided the psychiatric liaison service. The trust had developed an internal mental health development plan, which was in draft at the time of our inspection. This was to be reviewed by the mental health steering group before being presented to the trust board. The psychiatric liaison service was under review as part of the ‘Our Dorset’ system-wide review with expected recommendations in late 2018. With this in mind, the trust’s local plan clearly recognised collaboration with system partners was imperative in delivering high quality care and treatment to individuals with mental health needs. However, the plan also outlined internal improvement measures such as rolling out a network of mental health ‘champions’ across the trust and the development of an electronic toolkit to support staff in caring for patients with mental health needs.

Safeguarding leadership was an area of strength at this trust. We found the trust wide safeguarding leads to be proactive, responsive, very well informed regarding national safeguarding initiatives and there were clear links to the trust board.

**Board Members**

Of the non-executive board members at the trust, 27% were female. 13% of the non-executive board’s members were female. There were no Black and Minority Ethnicity (BME) members of the board at both executive and non-executive levels. The trust were aware that the board lacked cultural diversity and had sought to address this through recent recruitment initiatives but had not been successful in doing so.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>13%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>40%</td>
</tr>
</tbody>
</table>

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

**Vision and strategy**

The trust’s overarching mission was ‘providing the excellent care we would expect for our own families’. The trust had a clearly laid out strategy for 2015-20. The strategy was both externally focussed, in line with the reconfiguration of clinical services across Dorset, and internally focussed as it set out the trust’s unique set of priorities within the wider context.

The strategy clearly set out the strategic objectives, which included improvements in quality of care and patient experience, supporting and developing staff, developing as the main emergency site for East Dorset, improving timeliness of diagnosis and treatment and financial sustainability. In addition to the strategic objectives, trust leaders had also agreed three important quality
priorities. These were addressing sepsis, managing the deteriorating patient and improving patient flow. Clinical and non-clinical staff we spoke with were on board with these priorities. The trust had run a variety of initiatives to ensure these priorities were well understood by staff.

Internally, the trust had a vision, following our previous inspection in 2016, ‘to be the most improved trust by 2017’. To this end, the trust had invested heavily in organisational leadership development. The trust had refreshed the vision in January 2018, which was updated to ‘to work in partnership and continually improve services’. This vision had not been formally launched at the time of our inspection. Most staff we spoke with during the inspection were well aware of the trust’s previous vision to be the most improved trust. The majority of staff, when asked, thought the trust had achieved that vision, reporting favourably with comments such as ‘it feels like a completely different place to work’, ‘it’s like we have remembered why we come to work’ and ‘it is so much better than when CQC came before, a different culture completely’.

The trust had launched a ‘People Plan’ in November 2017 which brought together all of its workforce strategies. The People Plan focussed on attracting and retaining the right staff, rewarding staff and offering stretching opportunities for development. Senior staff we spoke with were aware of the People Plan. Less senior staff were not always aware of the People Plan but spoke of feeling rewarded and having ample access to training and development. To meet the People Plan, the trust had invested heavily in staff development. The trust had funded the provision of 25 Aston team coaches to support the leadership of effective teams, invested in change champions and trained over 250 staff in quality improvement methodology.

We viewed a wide range of promotional material, operational documentation and written communications, and saw how the trust embedded its vision, values, mission and strategy in corporate information received by staff teams, patients and the wider public.

The trust had a clear dementia strategy and an associated working group chaired by the trust’s dementia lead. We saw how the trust’s dementia strategy had led to real improvements for individuals living with dementia being treated at the hospital through initiatives such as orientation boards on the wards, more visible and clearer signage and automatic lighting in hospital bathrooms. The trust did not have a formal strategy for the care of individuals with mental health conditions other than dementia or for the care of individuals with a learning disability.

**Culture**

The culture at this trust was exceptionally positive. Every member of staff we spoke with, without exception, spoke of how much the culture had improved since 2015. Staff at all levels from a wide range of disciplines reported feeling proud to be of ‘# Team RBCH’. They described feeling valued in their work and reported feeling empowered to make changes in their work to improve patient safety and experience.

The trust had appointed a Director of Organisational Development and Leadership in 2015 who had undertaken a complex series of work streams to improve the culture within the trust. The trust had appointed 15 ‘change champions’ in late 2015 who in the ‘discovery phase’ had undertaken a huge cultural audit across the trust to determine what changes were required. The change champions were appointed through appropriate recruitment rigor and were from a broad range of skills, roles, bands and experience. The change champions included a junior doctor, a newly qualified nurse, a consultant and a volunteer.
The change champions had initially been tasked with finding out what it felt like to work at the trust. To this end, they held a wide range of focus groups, interviewed every member of the board, reviewed trust data such as complaints and staff survey results and looked externally to review what other trusts were doing in relation to culture. The champions themed the results which showed that staff wanted a more collective and inclusive style of leadership and senior leadership team that was more accessible and open.

The champions presented the findings to the board that, in turn, supported moving to the ‘design’ phase of the cultural improvement work. Since then, the trust had recruited approximately 30 change champions with each champion having to re-apply to the role annually. The change champions have been pivotal in bringing positive improvements in the leadership culture at the trust. This trust were winners of the 2017 Health Service Journal Awards in the category of staff engagement in recognition of this work on cultural improvement.

During the ‘design’ phase, the trust had implemented varied measures to improve culture. This had included the introduction of the role of Freedom to Speak Up Guardians, customer care and personal resilience workshops, matron and care group development programmes, improved mechanisms to reward staff and recognise good practice and the roll out of values based appraisals.

Staff we spoke with at all levels were familiar with the trust values of communicate, improve, pride, teamwork. The values had been agreed through collaboration with patients and staff. Staff wore lanyards with the values on them and we saw the values referenced in posters, patient literature and personnel records across the trust. Staff spoke of the values serving as a common language to use in addressing practice that did not meet trust expectations. For example, one senior nurse spoke of challenging a senior manager for not committing fully to the value of teamwork. Another staff member spoke of challenging a porter for not adhering to the value of pride by deriding the hospital. Managers addressed poor staff performance where needed. This went through all levels of the organisation and we saw clear evidence of how appropriate action had been taken by senior leaders to address staff behaviour and performance that was inconsistent with the trust’s vision and values.

Staff Diversity

As of January 2018, staff employed by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, belong to the following ethnicity groups:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>73%</td>
</tr>
<tr>
<td>Any other white background</td>
<td>8%</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>5%</td>
</tr>
<tr>
<td>Not stated</td>
<td>4%</td>
</tr>
<tr>
<td>Asian or Asian British – Indian</td>
<td>3%</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>3%</td>
</tr>
</tbody>
</table>
Black or Black British – African 1%
White – Irish 1%
Chinese 1%
Any other mixed background 1%
Mixed White and Asian 1%
Asian or Asian British – Pakistani 1%

Please note – the percentages in the above table have been rounded, therefore when summed they equal more that 100%

The trust did not provide an overall number of staff, so we are unable to provide exact figures.

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

The number of staff from BME backgrounds was largely reflective of the local population. However, BME staff were under-represented in senior leadership positions including board level positions, nurses in bands 6-9 and other senior leadership posts. The trust recognised the lack of ethnic diversity within the board membership. We were told they had tried to ‘positively recruit’ a board level director from a BME background but had not been successful as there were no suitable applicants.

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

This trust was ranked as the top performing acute trust nationally when compared with similar trusts in relation to the findings of the NHS Staff Survey in 2017. This had improved upon 2016 results whereby the trust was ranked second.

The trust has 27 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

Appraisals and support for development

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11 - % appraised in last 12 months (in the best 20% acute trusts)</td>
<td>96%</td>
<td>86%</td>
</tr>
<tr>
<td>KF12 - Quality of appraisals (in the best 20% acute trusts)</td>
<td>3.27</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13 - Quality of non-mandatory training, learning or Development (in the best 20% acute trusts)</td>
<td>4.12</td>
<td>4.05</td>
</tr>
</tbody>
</table>

Equality and diversity

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF21 - % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td>Errors and incidents</td>
<td>Key Finding</td>
<td>Trust Score</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>KF28 - % witnessing potentially harmful errors, near misses or incidents in last month (in the best 20% of trusts)</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>KF29 - % reporting errors, near misses or incidents witnessed in the last month</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>KF30 - Fairness and effectiveness of procedures for reporting errors, near misses and incidents (in the best 20% acute trusts)</td>
<td>3.83</td>
</tr>
<tr>
<td></td>
<td>KF31 - Staff confidence and security in reporting unsafe clinical practice (in the best 20% acute trusts)</td>
<td>3.80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and wellbeing</th>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KF17 - % feeling unwell due to work related stress in the last 12 months (in the best 20% of trusts)</td>
<td>34%</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>KF18 - % attending work in last 3 months despite feeling unwell because they felt pressure (in the best 20% of trusts)</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>KF19 - Organisational and management interest in and action on health and wellbeing (in the best 20% acute trusts)</td>
<td>3.80</td>
<td>3.62</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Working patterns</th>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KF15 - % satisfied with the opportunities for flexible working patterns (in the best 20% of trusts)</td>
<td>54%</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td>KF16 - % working extra hours</td>
<td>70%</td>
<td>72%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job satisfaction</th>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KF1 - Staff recommendation of the organisation as a place to work or receive treatment (in the best 20% acute trusts)</td>
<td>3.99</td>
<td>3.75</td>
</tr>
<tr>
<td></td>
<td>KF4 - Staff motivation at work (in the best 20% acute</td>
<td>4.01</td>
<td>3.92</td>
</tr>
</tbody>
</table>
trusts)

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF7 - % able to contribute towards improvements at work (in the best 20% acute trusts)</td>
<td>78%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8 - Staff satisfaction with level of responsibility and involvement (in the best 20% acute trusts)</td>
<td>4.04</td>
<td>3.91</td>
</tr>
<tr>
<td>KF9 - Effective team working (in the best 20% acute trusts)</td>
<td>3.88</td>
<td>3.72</td>
</tr>
<tr>
<td>KF14 - Staff satisfaction with resourcing and support (in the best 20% acute trusts)</td>
<td>3.52</td>
<td>3.31</td>
</tr>
</tbody>
</table>

**Managers**

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF5 - Recognition and value of staff by managers and the organisation (in the best 20% acute trusts)</td>
<td>3.64</td>
<td>3.45</td>
</tr>
<tr>
<td>KF6 - % reporting good communication between senior management and staff (in the best 20% acute trusts)</td>
<td>41%</td>
<td>33%</td>
</tr>
<tr>
<td>KF10 - Support from immediate managers (in the best 20% acute trusts)</td>
<td>3.89</td>
<td>3.74</td>
</tr>
</tbody>
</table>

**Patient care and experience**

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF2 - Staff satisfaction with the quality of work and care they are able to deliver (in the best 20% acute trusts)</td>
<td>4.06</td>
<td>3.91</td>
</tr>
<tr>
<td>KF3 - % agreeing that their role makes a difference to patients / service users (in the best 20% acute trusts)</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>KF32 - Effective use of patient / service user feedback (in the best 20% acute trusts)</td>
<td>3.83</td>
<td>3.71</td>
</tr>
</tbody>
</table>

**Violence, harassment and bullying**

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF22 - % experiencing physical violence from patients, relatives or the public in the last 12 months (in the best 20% acute trusts)</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>KF25 - % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (in</td>
<td>23%</td>
<td>28%</td>
</tr>
</tbody>
</table>
the best 20% acute trusts)

KF26 - % experiencing harassment, bullying or abuse from staff in last 12 months

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>22%</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>BME</td>
<td>25%</td>
<td>28%</td>
<td>27%</td>
</tr>
</tbody>
</table>

KF27 - % reporting most recent experience of harassment, bullying or abuse

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>46%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BME</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Whilst the trust ranked as top nationally, we observed clear commitment and intent to exceed on this year’s NHS staff survey success in 2018 at the March 2018 board meeting.

(Source: NHS Staff Survey 2017 - www.nhsstaffsurveys.com)

Workforce race equality standard

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

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

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Of the four questions above, the following questions showed a statistically significant difference in score between White and BME staff:

- KF21 – Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
- Q17b – In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017 - www.nhsstaffsurveys.com)

The trust did not have an established BME network at the time of our inspection. However, the Director of Improvement (DoI) had recently extended their portfolio to include diversity and inclusion in recognition of the further work that needed to be done. The CEO was the sponsor for
this work stream, which demonstrated the board’s commitment to prioritise this work. The DoI had introduced the diversity and inclusion trolley, which was used by relevant staff to engage with staff around the hospital and canvas their views about diversity and inclusion issues. We saw staff engaged in conversation about how the trust could further celebrate diversity and inclusion during our inspection. As part of our inspection, we also met with a variety of staff from a range of BME backgrounds who reported favourably about their experiences of working for the trust. BME staff told us they had the same access to career progression and that the trust supported all staff equally based on ability and potential rather than ethnic background. One member of the BME focus group had been supported to participate in the ‘stepping up’ programme, an NHS leadership academy programme for BME healthcare staff.

The trust had developed a People Plan for 2017-18. The plan included clearly set out objectives relating to diversity, inclusion and race equality. These included reviewing recruitment practices to ensure there were no hidden barriers and to attract even more widely and ensuring managers were as flexible as possible and equipped to support staff with particular requirements. In contrast to the Workforce Race Equality Standard results, staff we spoke with from BME backgrounds spoke favourably about their local leadership and being treated equitably. However, one BME staff member reported they were only able to take up to three weeks leave at a time, which prevented them from taking trips to their country of origin. Other BME staff said this had not been the case for all, suggesting there was some variability in line management approach.

The trust had held a number of events to celebrate diversity and promote inclusion. The trust held a tea party for nurses from the Philippines in 2017 to celebrate the 15 year anniversary of the arrival of the first recruitment round for these nurses. This was reported as a very positive event, which made the nurses feel valued by their peers and leaders. We also observed in a number of clinical areas that the trust had devised a #TeamRBCH inclusion calendar, which was used to highlight key culturally significant dates across the year and to promote diversity and inclusiveness across the trust. The calendar also included awareness dates such as January 2018 being thyroid awareness month. Several staff we spoke told us the calendar was invaluable in helping them plan support for specific staff groups.

The trust had an active lesbian, gay, bi-sexual, transgender (LGBT) network. The LGBT network had approximately 100 members and was made up of LGBT staff and non-LGBT staff who wanted to show their support to their colleagues. Staff within the LGBT network wore rainbow badges on their uniform to show their membership. Staff told us the LGBT network organised a variety of social events both inside and outside of the workplace and they ran a supportive social media forum that was accessible to all staff.

Friends and Family test

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

The trust consistently scored above the England average for recommending the trust as a place to receive care from December 2016 to November 2017.
Patients and their relatives we spoke with during the core service inspections spoke very positively about the care they received at this trust. Public governors at the trust also told us they receive consistent praise for the trust and that the public generally feel exceptionally proud of the high standard of care offered for Bournemouth and local area residents.

The role of the Freedom to Speak Up Guardian (FSG) had been well implemented at this trust. The trust had originally appointed two FSGs who worked alongside each other to promote the role and respond to any concerns raised by staff. Both the FSGs were awarded dedicated time to undertake the role. The FSG role had been well promoted. Initially, in April 2017, the trust appointed two FSGs, one for 15 hours per week and one for 7.5 hours per week, who worked alongside each other to promote the role and respond to any concerns raised by staff. Both the FSGs were awarded dedicated time to undertake the role, and the roles had been well promoted. The second post (7.5 hours) had ceased in March 2018 but the initial resource had supported the trust to embed the FSG role.

We saw posters throughout the hospital, screen savers, information available on the staff intranet and the FSGs regularly visited a range of services across the trust using the FSG trolley as a method of engagement. Staff we spoke with were all aware of the FSG and knew how to access them. The trust ensured the FSG could be accessed in a range of ways which included face to face, email, telephone or through the trust’s internal reporting system, LERN. In the annual FSG report to the board in March 2018, the FSGs had reported reaching over 1000 staff face to face through engagement events, training or other methods. This ensured there was a good level of staff knowledge about the FSG role throughout the trust.

The FSGs had received 45 contacts from staff wishing to speak up between April 2017 and mid-March 2018. Thirty of these related to issues concerning staff’s attitude and behaviour. The other
15 cases did not demonstrate any clear trends or themes. The highest numbers of staff contacting the FSGs were allied health professionals, closely followed by nursing staff. It was clear that the FSGs fully understood the requirements of the role and were usefully analysing data to inform their future priorities. They had outlined the FSG priorities as addressing poor behaviour, engaging with medical staff and staff from protected characteristics and collaborating with their neighbouring NHS trust in advance of the planned merger to create one FSG network. The FSG met with relevant board level directors on a monthly basis ensuring the board were sighted on FSG issues.

Staffside worked with the trust to ensure that staff were treated fairly and equitably at the trust. Staffside representatives told us executive and non-executive leaders were responsive to their concerns and listened to their views. Staffside shared the consensus view that the culture of leadership had improved significantly in recent years. They reported they were able to challenge board level leaders and hold them to account where appropriate.

The trust had a range of policies and procedures in place to support staff. These included procedures relating to staff appraisal, flexible working, long service awards, managing diversity and maternity, paternity and adoption. Staff had access to support for their own physical and emotional health needs through occupational health. Trust staff could also access a free, externally managed employee assistance helpline if they were experiencing any difficulties affecting their work. The majority of staff we spoke with were aware of this service and some had accessed the helpline, which they had found beneficial. In addition to the trust’s policies and procedures, the trust offered a broad range of wellbeing initiatives to all staff. These included a wellbeing link group offering 1-1 and group support, book club, alcohol management support, running club, Schwartz rounds and Pause for Thought self-help group.

The trust applied Duty of Candour (DoC) appropriately. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We reviewed a random sample of four investigations following incidents of moderate or serious harm and found that trust investigator had appropriately offered the patient and/or their relative a written apology, notified them of the investigation and the timescale for this and followed this up with the conclusion of the investigation including how the learning would be used to improve future patient outcomes. This is consistent with our impression of how DoC was well embedded in the trust’s culture and processes for investigating incidences of patient harm.

**Sickness absence rates**

The trust’s sickness absence levels from September 2016 to August 2017 paralleled the England average for the duration of the reporting period.
General Medical Council – National Training Scheme Survey

In the 2016 General Medical Council Survey the trust performed worse than expected for one indicator (Induction) and the same as expected for the remaining 13 indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance

However, junior doctors we spoke with consistently reported the trust was an effective training placement.

Board Assurance Framework

The trust had effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services which were regularly improved.

The trust provided their Board Assurance Framework (BAF) dated November 2017. The BAF was reviewed twice annually as a minimum by the Healthcare Assurance Committee (HAC) and trust board to identify risks to meeting their strategic objectives. The BAF format was appropriate, setting out structure, owners, risks, causes, controls, assurance, metrics, inherent risk, current risk and target risk. This provides details of 14 specific board objectives and accompanying risks, within three broader objective themes. A summary of these is below.

<table>
<thead>
<tr>
<th>Principal objective</th>
<th>Specific board objective</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuing our staff</td>
<td>Maintaining a turnover rate below 12%</td>
<td>Risk of not being able to recruit and retain appropriately trained staff to fulfil template/agreed levels of staffing to meet</td>
</tr>
<tr>
<td>Principal objective</td>
<td>Specific board objective</td>
<td>Risks</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>clinical/service needs.</td>
</tr>
<tr>
<td>Secure a CQC rating of at least good at next inspection</td>
<td>Risk of not achieving CQC “good” at next inspection and resultant impact on Trust reputation.</td>
<td></td>
</tr>
<tr>
<td>Deliver a QI flow project to improve safety and quality of inpatient emergency care.</td>
<td>Urgent Care – Front Door and Flow. If patient flow is compromised within the Trust, then there will be avoidable harm to those patients entering any front door to the hospital.</td>
<td></td>
</tr>
<tr>
<td>To improve discharge planning including establishing the IT systems to support the discharge planning database</td>
<td>Risk of delayed discharges impacting on patient care, flow and quality. Financial loss and possible cancellation of elective cases.</td>
<td></td>
</tr>
<tr>
<td>Improving quality and reducing harm</td>
<td>To improve discharge planning including the delivery of an education programme for the use of estimated data of discharge (EDD) and medically ready for discharge (MRFD)</td>
<td>Risk of delayed discharges impacting on patient care, flow and quality. Financial loss and possible cancellation of elective cases.</td>
</tr>
<tr>
<td>Ensure that 95% of patients or better are seen and treated/admitted within 4 hours and that the trust meets its agreed trajectory set in conjunction with NHSI</td>
<td>Urgent Care – Front Door and Flow. If patient flow is compromised within the trust, then there will be avoidable harm to those patients entering any front door to the hospital.</td>
<td></td>
</tr>
<tr>
<td>To ensure that every deteriorating patient with a NEWS of 9 or above is escalated for review and seen by an appropriate clinician within 30 mins of their initial</td>
<td>Risk that the Trust fails to consistently recognise, escalate and manage deteriorating patients; failure to do so will potentially cause</td>
<td></td>
</tr>
<tr>
<td>Principal objective</td>
<td>Specific board objective trigger</td>
<td>Risks harm to patients.</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>To treat everyone with sepsis related organ failure assessment within one hour and all other sepsis patients with 3 hours of admission/diagnosis of sepsis by giving a first dose of antibiotics.</td>
<td>Sepsis recognition and treatment including ABX provision within 1 hour is a control.</td>
<td>Non-compliance with 18 week RTT 92% target; risk of escalation by NHSI and clinical impact of delays to patient treatment.</td>
</tr>
<tr>
<td>92% of patients on an 18 weeks pathway are treated or discharged within 18 weeks of referral</td>
<td>Services sustaining cancer fast track referral of 2 week wait currently. Delivering 62 day treatment continues to be at risk of breaching KPI.</td>
<td></td>
</tr>
<tr>
<td>85% of patients or better on a 62 day cancer pathway receive their treatment in that period</td>
<td>Ensure services are provided in a cost effective way and the Trust meets its financial plan to deliver a control total of £6.6 m deficit or better</td>
<td>High demand of fast track referrals and inability to align capacity to meet RTT/cancer waiting times. Area most at risk is Urology.</td>
</tr>
<tr>
<td>Implement the CSR</td>
<td>The risk in not being able to progress the Clinical Service Review; it will manifest in a number of ways.</td>
<td></td>
</tr>
<tr>
<td>Strengthening team working</td>
<td>1. The failure to comply with national recommendations regarding the provision of safe, sustainable emergency care due to the inability to create critical mass and respond to known workforce challenges.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. The frustration of plans to obviate future expenditure and therefore maintain services within the funding allocated via the tariff system. This will result without subsidy in the</td>
<td></td>
</tr>
</tbody>
</table>
The trust board met regularly. Meetings were held in two parts, the first being in public, which started at 8.30 am to allow working individuals more opportunity to attend. The board then met in private. At the beginning of each board meeting there was a patient story. We observed a board meeting held in March 2018 whereby the lead tissue viability nurse presented a patient story about a complex discharge. The patient story generated discussion based on the patient’s pathway and experience, rather than solely on their clinical treatment and outcomes. The previous board meeting had included a patient story from the relatives of a patient who had died at the hospital where there were some shortfalls in care. Both executive and non-executive directors told us they considered patients’ stories were essential in helping the board focus on ensuring services were centred on the needs of people using services.

We attended one board meeting (public and private) and found both parts were effectively chaired. It was the end of the financial year so there were many agenda items but the meetings ran mostly to time and all agenda items were covered and given due regard. The patient story facilitated by the tissue viability nurse was presented in an open and transparent way, identifying both things that had gone well and not so well. We saw there was sufficient challenge at the board meeting from both the wider public in Part 1 and the NEDs in Part 2. We noted in Parts 1 and 2 of the board meeting there was a strong focus on assurance and a diligent approach to ensuring follow up actions were taken through the relevant committees and sub-committees.

There was an appropriate range of committees and sub-committees that reported directly to the board. The committees that reported directly to the board were audit, finance and performance, charitable funds, workforce strategy and development and nomination and remuneration.
Additionally, there was the Healthcare Assurance Committee, which was the main committee that provided assurance to the board around clinical governance and risk management. A NED with relevant experience and interest in that particular area chaired each committee. A range of sub-groups supported individual committees. For example, the capital management, payment by results, service line reporting and performance management groups reported upwards to the finance and performance committee that reported directly to the board.

There were a range of both scheduled and exception reports that were fed into the range of committees. We reviewed a range of committee and sub-committee agendas, corresponding minutes and associated reports. These clearly evidenced robust discussions, the assignment of relevant actions and the clear reporting lines between the various committees. However, a number of executive and non-executive directors reported that the audit committee did not have a sufficient voice within the trust, which the BoD were seeking to redress. We had no concerns about the functioning of the audit committee when reviewing the minutes of the meetings though we noted there was some confusion within the board about the role of the HAC and the audit committee and how they related.

The healthcare assurance committee (HAC) had 10 sub-groups, which provided a broad remit. This included information governance, health and safety, safeguarding, medicines management and mortality surveillance. The NED responsible for chairing the HAC had exemplary oversight of the key risks and issues across the trust. They reported that whilst the remit of the HAC was vast, it was manageable and effective. We saw that there were clear reporting lines to the HAC. The HAC reviewed and took accountability for the quality dashboard, which provided timely data on patient safety, experience and quality.

At department and ward level, in the services we inspected, we found that staff were clear about their roles and their level of accountability. Ward staff told us of regular team and business focussed meetings and we observed minutes of some of these meetings. Overall, we found staff to be knowledgeable about how governance worked at the trust. We noted there was a standardised approach to agendas, meetings and minutes, which supported ward to board reporting.

The trust had appropriate governance arrangements in place for the management of patients with mental health needs through service level agreement with the local mental health provider. The NHS mental health provider which delivered the psychiatric liaison service to the hospital was PLAN (Psychiatric Liaison Accreditation Network) accredited until October 2019 which gave assurance to trust level directors about the quality of the service. The mental health steering group monitored the ongoing effectiveness of mental health provision at the trust.

Management of risk, issues and performance

The trust had reviewed and replaced its incident reporting system in 2017. To support the launch of the new system, referred to as LERN, the trust had widely publicised its #share to care initiative. Staff were presented with accounts of how sharing examples of both positive and negative care had improved future delivery of care. Similarly, staff were positively encouraged to share experiences of care in order to improve. The LERN system allowed staff to report in four areas through the electronic system. These were; incidents, celebration of something done well, raise an issue or concern or suggest an improvement idea. Staff we spoke with were highly praising of LERN. They reported it not only identified incidents or risks but also it could prevent future risks through early identification or improving practice. The LERN system also linked to other resources in the trust, for example, issues or concerns could be flagged by the reporter to the freedom to speak up guardian.
Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Each Directorate had a locally managed risk register providing assurance at a local level that there was a planned and systematic approach to the identification, assessment and mitigation of the risks. Each directorate had designated individuals who had access to upload, review, accept and amend information on risk register software. The level of scrutiny and oversight required for each risk was determined by the risk rating. For example, very low risks (scores of 1-3) required review and sign off by local leaders whereas significant risks (scores of 12-25) required review by the HAC, trust management board and the level of risk needed to be accepted by the board.

The trust board had sight of all of the most significant risks on the risk register, mitigating actions were clear, and accurately documented. Staff had access locally owned risk registers and priority risks were escalated onto the trust wide risk register. All significant risks were reviewed at the HAC before being agreed by the trust board. A detailed monthly trust risk register report was presented to the trust board. This report gave oversight of the key significant risks but also identified the current level and future level of risk appetite (the amount and type of risks they were willing to accept in order to meet the strategic objectives).

**Trust corporate risk register**

The trust provided a document detailing their 10 highest profile risks as at November 2017. Each of these has a current risk score of 12 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/9/2017</td>
<td>649</td>
<td>Secure the lifting of the undertaking placed on the Trust by the Competition and Markets Authority</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>05/09/2013</td>
<td>214</td>
<td>The ED middle grade budget is 12.41 WTE which is currently not being met. This lack of cover means reliance on locum, impacting financially. This also has an impact on patient care and supervision of juniors.</td>
<td>12</td>
<td>19/10/2017</td>
</tr>
<tr>
<td>12/01/2017</td>
<td>463</td>
<td>If patient flow is compromised within the Trust, then there is a risk there will be avoidable harm to those patients entering any front door to the hospital</td>
<td>12</td>
<td>26/10/2017</td>
</tr>
<tr>
<td>06/01/2017</td>
<td>457</td>
<td>If the trust continues to miss significant diagnostic results then there is a risk this will</td>
<td>12</td>
<td>09/01/2017</td>
</tr>
<tr>
<td>Date risk opened</td>
<td>ID</td>
<td>Description</td>
<td>Risk score (current)</td>
<td>Last review date</td>
</tr>
<tr>
<td>------------------</td>
<td>-----</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>23/12/2016</td>
<td>452</td>
<td>If the number of stranded patients in the hospital (patients in hospital for 7+ days) remains at the current levels, then there is a risk there will be potentially avoidable harm to those patients.</td>
<td>12</td>
<td>08/11/2017</td>
</tr>
<tr>
<td>30/03/2017</td>
<td>604</td>
<td>There is a risk that demand management initiatives will not be fully supported and/or implemented effectively out of hospital which could impact on the elective services at RBCH; resulting in capacity issues and therefore, delays to patient pathways, waiting list performance failure and financial imbalance.</td>
<td>12</td>
<td>30/10/2017</td>
</tr>
<tr>
<td>31/03/2017</td>
<td>466</td>
<td>Current resourcing levels in IT security is resulting in the trust being reactive to cyber-threats as opposed to proactive. This could result in services being offline for days.</td>
<td>12</td>
<td>15/10/2017</td>
</tr>
<tr>
<td>31/10/2015</td>
<td>307</td>
<td>The current management and resourcing of the oncology medical cover to our patients is not sufficiently resilient to provide a safe service.</td>
<td>12</td>
<td>28/09/2017</td>
</tr>
<tr>
<td>06/09/2017</td>
<td>645</td>
<td>Risk that the current ESR (non-portal) access route will be removed in December 17 and access to ESR will not be available to users. Likely loss of all essential payroll, training, staffing and contract functions.</td>
<td>12</td>
<td>27/10/2017</td>
</tr>
<tr>
<td>31/03/2016</td>
<td>193</td>
<td>Delayed treatment pathways, non-compliance</td>
<td>12</td>
<td>30/10/2017</td>
</tr>
</tbody>
</table>
Where incidents occurred the trust investigated and identified appropriate learning which was shared across the trust and wider as appropriate. Duty of Candour requirements were given sufficient priority and trust leaders were highly committed to learning in an open and transparent way when things went wrong. We reviewed a sample of serious incident investigation reports and noted they were exceptionally thorough and there was evidence of sufficient scrutiny being applied within an open and just culture. Patient and relative involvement was inherent within the investigation process. The trust were investigating an average of 25-30 serious incidents at any given time. On average, there were three serious incident panels held weekly where these incidents would be reviewed and the learning and corresponding actions agreed. The quality and risk team produced a weekly quality and risk update through the intranet which included details of learning from incidents. Trust leaders had a good grip on the numbers, trends and themes of incidents arising and we found this was shared appropriately with staff at all levels in ways that were appropriate to their roles.

The trust urged patients to identify when their care fell below expectations and invested in ensuring there were a variety of ways that patients and their relatives could raise concerns. The CEO had overall accountability for complaints made about the trust with responsibility delegated to the DoN. The CEO ultimately signed off all complaint response letters. The trust had an identified NED responsible for complaints. The complaints manager had day-to-day responsibility for the handling of complaints.

The trust had a target of 75% of all complaints to be investigated and responded to within 25 days. In the trust’s annual complaints report of 2016-2017, it was reported that 76% of complaints were responded to within the target timescale. It was noted that this was set to improve further in 2017-18 as the timescales were due to be reviewed. The trust had improved this to 81% in the reporting year prior to our inspection, as shown in the table below. During our inspection, several director level staff told us the complaint response process was to be revised to allow for a ‘triage’ which would enable the trust to identify more realistic timescales for complex or more challenging complaints.

During 2016-17 the trust received 293 complaints. The trust took action to review complaints to identify trends or recurring themes. For 2016-17 the main proportion of complaints were identified as implementation of care, communication and consent and admission, transfer and discharge. The complaints performance group reviewed the themes and prevalence and these were disseminated to and discussed in the care group meetings. We saw clear evidence of learning from complaints during our core service inspections.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.
| What is your internal target for responding to complaints? | 3 working days | 100% |
| What is your target for completing a complaint | 25 days | 81% |
| If you have a slightly longer target for complex complaints please indicate what that is here | N/A | N/A |
| Number of complaints resolved without formal process in the last 12 months? | 1,420 | N/A |

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

**Number of complaints made to the trust**

The trust received 274 complaints from October 2016 to November 2017. Medicine received the most complaints with 110.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>110</td>
<td>40%</td>
</tr>
<tr>
<td>Surgery</td>
<td>82</td>
<td>30%</td>
</tr>
<tr>
<td>Other</td>
<td>63</td>
<td>23%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>End of life care</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Critical care</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Maternity</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Urgent and Emergency Care</td>
<td>1</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

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

**Compliments**

From November 2016 to October 2017, the trust received a total of 3,195 compliments recorded using the Friends and Family Test. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>1,424</td>
<td>45%</td>
</tr>
<tr>
<td>Surgery</td>
<td>1,423</td>
<td>45%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>201</td>
<td>6%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>147</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>3,195</td>
<td>100%</td>
</tr>
</tbody>
</table>

In addition to the compliments displayed above, the trust has received a number of compliments recorded using other methods.
From December 2016 to November 2017, 112 compliments were registered on the trust’s #ThankYou! website.

From December 2016 to October 2017, 45 individual complimentary cards, emails, letters and phone calls were recorded by the trust.

Complimentary cards and letters are also sent directly to the Chief Executive’s office. From December 2016 to October 2017, 111 compliments were received in this way.

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

The trust had a clear process for reviewing deaths that occurred at the hospital. Consultants were notified electronically of all deaths of patients under their care on a monthly basis. The consultants reviewed initially through an electronic form and used a scoring system to determine whether further investigation was required. Any unexpected death was raised through LERN incident reporting and was investigated as per the trust's usual incident reporting protocols. The trust ran a mortality steering group, which reviewed mortality performance, themes arising from mortality reviews and ensured national learning around mortality was captured. The trust produced a quarterly mortality newsletter for all staff, which captured key learning from across the directorates. Clinical staff we spoke with across the trust were aware of the mortality newsletter and could give examples of learning from death reviews.

This trust had shown a consistent improvement in mortality metrics in the two years prior to our inspection. The trust had undertaken mortality reviews for 56% of patients who died at the hospital in 2016-17. Further to this, the trust refreshed its mortality review policy in December 2017 and had pledged to review all in-patient deaths that occurred at the hospital. Mortality reviews provide a structured way of identifying quality gaps in care.

The DoN was the executive lead for safeguarding. Information we reviewed and our discussions with safeguarding leads for adults and children indicated there was evidence of good practice in this area of risk. This included joint working between the trust and external agencies in order to achieve positive outcomes for patients. The trust had a named nurse, midwife and doctor for safeguarding. We saw clear evidence of learning from safeguarding reviews. For example, a serious case review had identified that all midwives needed to attend domestic abuse training which was actioned. There were a number of processes in place to ensure that safeguarding was sufficiently prioritised. The lead professionals met monthly, there was a quarterly Trust Protection and Safeguarding meeting (TPSC) which in turn reported to the trust board via the HAC.

Finances Overview

Trusts leaders understood the trust’s financial position and knew transformation was essential for the trust’s long-term sustainability. The trust benchmarked favourably against other trusts when analysed using the NHS Improvement Model Hospital tool. The trust was in the highest (best) quadrant for ‘better productivity, sustainable finances’ using the ‘Quality Efficiency Deficit’ chart, which provides an overall picture of trust performance. The trust had a robust process for the development and monitoring of Cost Improvement Plans (CIPs), which included working closely with system partners to develop joint plans where possible. The trust had a finance risk register, which was discussed monthly at the finance and performance committee, and included financial risks both internal and external to the trust. Wider risk register entries were considered when trust leaders were prioritising cases for financial investment.
### Historical data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£273m</td>
<td>£290.5m</td>
<td>£284m</td>
<td>£285.5m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£11.5m)</td>
<td>£2m</td>
<td>(£6.5m)</td>
<td>(£6.5m)</td>
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<tr>
<td>Full Costs</td>
<td>£284.5m</td>
<td>£288.5m</td>
<td>£290.5m</td>
<td>£292m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£13m)</td>
<td>(£1.5)</td>
<td>(£6.5m)</td>
<td>(£6.5m)</td>
</tr>
</tbody>
</table>

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

There were robust plans in place for emergencies such as adverse weather, a flu outbreak or a disruption to business continuity. We were hugely impressed with how the trust responded to being at OPEL 4 (the highest operational pressures escalation level). Whilst we observed huge pressures on staff and leaders during our inspection, leaders remained calm, followed protocols and focussed on patient safety and experience.

### Information management

The trust had a shared informatics function with their neighbouring trust. Together they had a shared informatics strategy which had been refreshed in an updated document entitled ‘Re-base and Re-focus’ in March 2017. The strategy outlined work plans to achieve a shared vision which was ‘to make patient care safer and more efficient and improve the working lives of staff by using modern informatics’.

The trusts were working with system partners towards the development of the Dorset care record, the implementation of linked clinical information between acute, mental health and primary care. Whilst this was a longer-term project, the trust had internally utilised technology to improve clinical care. Examples included Vitalpac for clinical observations, eNurse for risk assessments and ICIP for a paperless Intensive Care Unit. Additionally, the trust were implementing Sunquest ICE for order communications and results reporting by 2018 which was already live within primary care. The trust website had links to a range of electronic self-assessment tools that included diabetes, bladder, alcohol, kidney disease, fertility and healthy eating.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Staff had access to the IT equipment and systems needed to do their work. IT systems and telephones were working well and they helped to improve the quality of care. The use of quality metrics to support and improve care was well embedded across the trust.

Data quality was overseen by the Senior Information Risk Owner (SIRO) and discussed regularly at the Information Governance Committee. Senior staff we spoke with were confident that the data provided by the trust was sufficiently accurate and timely. The NEDs spoke of the need to
triangulate data to be assured of its accuracy. The trust produced ward to board quality reports which pulled together a range of performance metrics for individual services, directorates, care groups and the trust overall. This Quality and Risk Committee reviewed the quality dashboards, which reported then by exception to the board. We reviewed the quality dashboards for the three care groups and found they provided an integrated range of data from treatment waiting times to pertinent workforce issues. The trust wide quality dashboard was publicly available on the trust website.

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital on 31 March each year. The purpose of the IG Toolkit is to provide assurance of an organisation’s information governance practices through the provision of evidence of around 45 individual requirements. The self-assessment must be submitted to NHS Digital, with all evidence uploaded by 31 March 2017. The Trust’s Information Governance Assessment Report overall score for 2016/17 was 74% and was graded as “Satisfactory”. The trust auditors monitor compliance with the IG toolkit on an ongoing basis. The trust’s IG toolkit compliance was reported and published annually through the trust’s quality account.

The trust produced a wealth of patient information including over 1,200 leaflets as well as brief guides, posters and web based information. In 2013, the trust was awarded the Information Quality Standard Mark from the Royal Society of Public Health which provides assurance that the information provided was clear, concise, evidence based and current. The trust has remained accredited since 2013.

The trust submitted notifications to the Care Quality Commission in the past year in line with their statutory responsibilities. The commission received notifications about never events that occurred and safeguarding. In addition to the statutory notifications, the trust have routinely provided additional information as requested in an open, transparent and timely way.

**Engagement**

The trust had structured methods for receiving feedback from people who used services, those close to them and their representatives. From ward to board level, staff had access to patients, carers and relative’s feedback and used this information to make improvements. The trust had set out its approach to patient and public engagement in its published ‘Interim Patient Experience and Public Engagement Strategy’ in January 2018. In this interim strategy, the trust shared its ambition to work towards a model of co-design – that is providers, stakeholders, recipients of healthcare and the wider public working together in designing models of delivering care. Whilst this ambition was longer term, the trust were receiving regular and sustained feedback from patients and the wider public in a variety of ways. This included; national patients surveys such as maternity, cancer care, emergency care and outpatients; friends and family test; local patient surveys such as the care campaign audit and patient reported outcome measures (PROMS).

The trust had found ways to improve the response rates from patients in giving feedback. For example, in the emergency department, they had introduced text feedback for patients and relatives and in outpatients they had introduced feedback boxes where visitors could post a card into an appropriately rated box. Both initiatives had significantly improved response rates.

The trust had patient focus groups in a range of clinical services, which supported service improvements. For example, the endoscopy focus group had informed changes to the waiting area and in outpatients they had developed a patient participation network to support with ongoing improvements.
The trust, alongside system partners, also prioritised engagement with patients and the wider public when planning or developing services or improvements. For example, in May 2017 adverts were placed locally for people living in and around Dorset to join a Public Engagement Group (PEG) as a key part of the work to improve health and care across the county. In addition to the engagement events with system partners, the trust also independently held public facing events in nine locations across the county in 2017 including a local hotel, a shopping centre, a school and a library.

The trust held frequent engagement events in the local community aimed at increasing public health awareness and raising the profile of the trust locally. For example, the trust held a series of general interest talks on health matters in a local hotel opposite the hospital. These were advertised through the trust website, social media channel, publications for members and with press releases via the local press. Recent topics included stroke; heart disease; skin care; end of life care. These events gave the trust an opportunity to engage with the public, give updates on any developments and encourage members of the public to become trust members.

The trust had a proactive and integrated communications team. For example, when the trust were at OPEL 4 status, we observed the communications lead at the escalation meeting so key messages could be agreed and shared with patients, staff and the wider public. The trust communications team took a proactive approach to media relations and the trust regularly featured in the local press. The trust had won a national award in 2017 from the Association of Healthcare Communications and Marketing for an article about the care journey of an elderly patient. Throughout our inspection, we followed a range of social media platforms for the trust and found their communications to be appropriately positive but balanced with an open and transparent approach.

The trust had developed an exemplary system of praise for staff, which could be utilised by all staff, patients, visitors and the public wishing to thank individuals or specific teams within the trust. The initiative known as ‘#thankyou’ had been exceptionally well received by staff as they were able to ensure their colleagues were recognised. Similarly, some relatives and patients we spoke with had used #thankyou as a platform for thanking staff when they had received good care. Staff we spoke with said #thankyou had really improved the culture, as there was ongoing recognition of staff’s hard work. In 2017, the trust held a #thankyou reward and recognition event for staff that had been well attended and received by staff. Over 1300 staff attended the event. We reviewed some examples of #thankyous which included a thank you to an individual manager from a staff member, a thank you to individual staff from colleagues for working additional hours and a thank you from the granddaughter of a woman who had attended the emergency department with a suspected stroke.

Staff engagement was a clear area of strength at this trust. Trust leaders had invested in understanding staff’s preferred communication methods. Further to the change champion work already described, the trust had introduced change engagement champions whose role it was to directly engage with staff and to feedback their views, aspirations and concerns. In addition, the trust had used a local digital agency in September who met with 10 teams around the trust to try and understand which communication channels were really valued and used by staff. The results were being used by the communication team to inform the trust’s engagement with staff.

The trust had used an engagement trolley to engage and visit staff across a variety of services on a variety of issues. Staff told us they appreciated various trust leaders taking the time out to visit them, particularly on wards that were difficult for staff to leave during their shift. Specific leads had used the engagement trolley to engage with staff on issues such as flu jab uptake, freedom to speak up and diversity. The engagement trolley had been used to visit over 20 different areas of the trust in the year prior to our inspection.

The trust produced a newsletter called ‘Buzzword’ that shared broadly what had been going on across the trust. Additionally, the CEO produced a monthly briefing entitled ‘Core Brief’. The CEO held a monthly face-to-face briefing that all staff were able to attend if they wish.
Governors played an important role in engaging with patients and the public. The governors had a structured engagement plan in place whereby they held a listening event most months. In addition, the Council of Governors held a quarterly meeting open to the public and staff. The trust had over 10,000 foundation trust public members. When we spoke with the governors, they reported the lower age limit for public members had been reduced to 12 years old to try to increase the uptake of younger members. Governors reported that trust leaders made considerable effort to engage with the Council of Governors.

The trust had signed up to the Dorset Carer’s Card scheme. The Dorset wide scheme had been introduced in June 2016 and entitled recognised carers to discounted parking and food and drink at the hospital site. This had been well received locally with lots of positive media coverage.

**Learning, continuous improvement and innovation**

**Accreditations**

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

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

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Medicine</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Surgery</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS) – <em>working towards</em></td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189 – <em>working towards</em></td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Joint Accreditation Committee of International Society for Blood and Marrow Transplantation (JACIE)</td>
<td>Medicine</td>
</tr>
</tbody>
</table>

(Source: *Routine Provider Information Request (RPIR) – Accreditations*).

Trust leaders were highly committed to creating a culture that supported ongoing learning, continuous improvement and innovation. The trust had enabled service line managers and all staff to engage with continuous improvement through the role of the change champions, the LERN reporting system (sharing of a good idea) and through the training of Aston team coaches to build effective and resilient teams. The trust had trained over 250 staff in quality improvement methodology and was running a junior doctor quality improvement programme. All staff at all levels felt empowered and had the right tools in place to contribute meaningfully to service improvement.

The trust ran action learning weeks where staff could focus on a particular issue and explore what the barriers were and where the challenges came from in order to identify solutions. The trust also facilitated an annual patient safety and quality improvement conference to give staff the
opportunity to share best practice and learn from others. At the 2017 conference, over 50 posters were displayed outlining quality improvement projects that had improved patient safety and experience. Many staff we spoke with throughout the inspection could tell us of quality improvement projects they had been involved in.

The trust had been recognised through a variety of awards and nominations within the reporting year for a range of innovative practice that included –

- The voluntary services team had received a national award for its End of Life Companion initiative. The team won the National Association of Voluntary Service Manager’s Excellence in Volunteer Management Award for the way it has set up and managed the new End of Life Companion (EOLC) voluntary role.
- The change champions won the Health Service Journal’s (HSJ) award for staff engagement for their work on culture change in the Trust.
- A haematology consultant was named Inspirational Woman in Science and Technology at the 2017 Dorset Venus Awards for her dedication to science in her work in treating blood cancers.
- The Christchurch hospital team, physiotherapy team and orthopaedics had each received HSJ nominations.
- The education team was shortlisted for the Healthcare People Management Association’s award for Employee Engagement.
- The Freedom to Speak Up Guardians were runners up in the communications category of the Annual National Freedom to Speak Up Conference. They received the commendation for their work in equality, diversity and human rights week in May. They were praised for their simple approach to frontline, face-to-face conversations using the roaming trolley.
- The Theatres Practice Education Team won silver at the Health Heroes Awards for their workforce planning. The award was given for the team’s work on recruitment and retention resulting in half the numbers of vacancies.
- BERTIEonline, an online platform offering structured education for people with Type 1 diabetes, was selected as a finalist in the ‘Digital and Technology Solutions in the Treatment or Management of Diabetes’ category in the Quality in Care (QiC) Diabetes 2017 Awards.
- The acute pain service offered cognitive behavioural therapy for orthopaedic patients before their operations. The service offered three sessions of therapy to help patients reframe their thoughts towards pain and had resulted in patients being discharged home sooner than those who did not use the service. This initiative was among six finalists in BMJ 2018 awards.
Urgent and emergency care

Facts and data about this service

The emergency department (ED) for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) is based on the Bournemouth hospital site. The ED is open twenty-four hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries, which need prompt treatment.

The ED at RBCH was not a trauma unit. Trauma patients that present at RBCH were assessed stabilised and then transferred to another NHS hospital for further treatment and assessment.

At the time of our inspection, the department consisted of a 3-bay resuscitation area; one resuscitation bay contained equipment for children, although children requiring an ambulance were taken to the specialist children’s emergency facility elsewhere. There was a 13-bedded majors area; a minors area, which included a paediatric assessment cubicle, and two observation bays used for rapid access and treatment (RAT). A triage system was in place to enable staff to prioritise patients according to medical need.

A helipad was located just outside the ED, which the local air ambulance services used to bring patients from remote locations and transfer out to tertiary centres as required. Co-located within the ED was a radiology suite with digital imaging facilities.

We previously undertook a comprehensive inspection of urgent and emergency care in October 2015. At that time we rated the service in the emergency department as requires improvement for safe, effective, responsive and well-led services. Care of patients was good.
During our inspection, we spoke with a range of staff at all levels, patients and relatives and reviewed sets of patients’ notes.

Activity and patient throughput

From Insight
93,844 Oct 16 - Sep 17 a 3% increase on the year before
Attendees arriving by ambulance (total) 22,898 Oct 16 - Sep 17 a 2% increase on the year before
Children attending A&E (total) Oct 16 - Sep 17 13,374

Activity and patient throughput

Total number of urgent and emergency care attendances at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust compared to all acute trusts in England
There were 93,761 attendances from April 2016 to March 2017 at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust as indicated in the chart above. 
(Source: NHS England)

Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased from 2015/2016 to 2016/2017. In 2016/2017, rates were higher than the England average.
(Source: NHS England)

Urgent and Emergency Care attendances by disposal method
* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment
(Source: Hospital Episode Statistics)

Is the service safe?

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

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

Mandatory Training

The service had made great effort to ensure all staff completed mandatory training. Staff did not meet the trust target for mandatory training compliance, but the compliance was increasing.

The service set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of November 2017 for medical/dental and nursing/midwifery staff in urgent and emergency care is shown below.

Mandatory training completion rates – medical and dental staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>95%</td>
<td>61</td>
<td>66</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>95%</td>
<td>61</td>
<td>67</td>
<td>91%</td>
<td>No</td>
</tr>
<tr>
<td>WRAP Training</td>
<td>95%</td>
<td>61</td>
<td>67</td>
<td>91%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>95%</td>
<td>60</td>
<td>67</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>60</td>
<td>67</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity &amp; Human Rights</td>
<td>95%</td>
<td>59</td>
<td>67</td>
<td>88%</td>
<td>No</td>
</tr>
<tr>
<td>Security, Violence &amp; Fraud</td>
<td>95%</td>
<td>59</td>
<td>67</td>
<td>88%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical and dental staff did not meet the target of 95% completion for any of the 15 training courses.

**Mandatory training completion – nursing staff**

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity &amp; Human Rights</td>
<td>95%</td>
<td>167</td>
<td>168</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>95%</td>
<td>166</td>
<td>168</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security, Violence &amp; Fraud</td>
<td>95%</td>
<td>166</td>
<td>168</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Sharps-Level 2</td>
<td>95%</td>
<td>164</td>
<td>168</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>95%</td>
<td>162</td>
<td>168</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>157</td>
<td>164</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>95%</td>
<td>318</td>
<td>336</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>95%</td>
<td>155</td>
<td>164</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>157</td>
<td>168</td>
<td>93%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>156</td>
<td>168</td>
<td>93%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia-Tier 2</td>
<td>95%</td>
<td>156</td>
<td>168</td>
<td>93%</td>
<td>No</td>
</tr>
<tr>
<td>WRAP Training</td>
<td>95%</td>
<td>154</td>
<td>167</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>95%</td>
<td>114</td>
<td>126</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>284</td>
<td>316</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>150</td>
<td>167</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>148</td>
<td>168</td>
<td>88%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>147</td>
<td>168</td>
<td>88%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>95%</td>
<td>125</td>
<td>168</td>
<td>74%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3-Adult Immediate Life Support</td>
<td>95%</td>
<td>19</td>
<td>42</td>
<td>45%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff met the target of 95% completion rate for eight of the 19 training courses.

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

At the time of our inspection, the overall completion rate for mandatory training for the whole team had reached 87%. The nurse lead for education told us that the current achievement was still on trajectory for improving against the target for the year and compared with two years ago there had been a great deal of improvement. At the time of our last inspection, some of the elements of mandatory training had achieved compliance rates as low as 28% and overall compliance at about 63%.
The education lead explained the poor compliance level for fire training; in previous years, a fire safety officer had arranged several training sessions in the department for staff to access without too much service disruption. A new fire safety officer was unable to offer this service and some staff had not been able to attend one of the trust sessions. This was being addressed at the time of our inspection.

All staff we spoke with told us that they could complete most of their mandatory training on line and that managers allocated time for this, or staff were paid if completed in their own time.

**Safeguarding**

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Safeguarding adults and children formed part of the trust’s mandatory training programme. The trust required all staff to complete safeguarding adults and safeguarding children levels one and level two for all clinical roles. In addition to this, designated specialist staff within the emergency department were required to complete safeguarding children level three training.

The trust set a target of 95% for completion of safeguarding training.

The 95% target was met for none of the safeguarding training modules for which medical staff in urgent and emergency care were eligible.

Staff met the 95% target for three of the four safeguarding training modules for which qualified nursing staff in urgent and emergency care were eligible.

A breakdown of compliance for safeguarding training courses as of November 2017 for medical and nursing staff in this core service is shown below:

**Safeguarding training completion rates – medical and dental staff**

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>61</td>
<td>67</td>
<td>91%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>61</td>
<td>67</td>
<td>91%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>61</td>
<td>67</td>
<td>91%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>12</td>
<td>15</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>
Safeguarding training completion rates – nursing staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>165</td>
<td>168</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>163</td>
<td>168</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>161</td>
<td>167</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>53</td>
<td>69</td>
<td>77%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff in the emergency department did not meet the 95% compliance standard for safeguarding training. However, staff met the target in three of eight elements and missed marginally in three others.

The safeguarding children’s lead for the department was trained to level four.

An electronic child safeguarding process, which identifies all children and ensures that a safeguarding assessment is completed had been introduced, and we saw a laminated copy of the criteria and the safeguarding referral process readily available to staff. We observed clinical staff completed a safeguarding assessment during a patient consultation.

Staff had an awareness of female genital mutilation (FGM) though none that we spoke with had seen a case. Staff we spoke with were able to tell us the processes for referral quite clearly.

The trust had safeguarding leads in directorates across the trust; the trust executive lead for safeguarding was the Director of Nursing and Midwifery. There were internal and external meetings in the trust to ensure appropriate escalation of safeguarding issues took place. Staff we spoke with were confident of the process for raising safeguarding concerns and who their local leads were.

Cleanliness, infection control and hygiene

The service controlled infection risks well. We observed good compliance with the use of control measures to prevent the spread of infection.

All areas of the ED we visited were visibly clean.

Reliable systems were in place to prevent and protect people from a healthcare associated infection in line with National Institute of Health Care Excellence guidelines (NICE QS61, 2014). Staff in the department were aware of the infection control and prevention policy, and could appropriately identified patients requiring screening for influenza and infections such as methicillin-resistant staphylococcus aureus.

Managers expected staff to undertake training in infection prevention (Level 2); up to November 2017, the medical staff were 82% compliant and the nursing staff were 88% compliant against the trust 95% target

Cleaning schedules were in place and we saw staff members followed these. These schedules included the cleaning of commodes, toilets and curtains.
Staff we spoke with told us that both domestic and nursing staff had responsibility for ensuring the cleanliness in the department. For example, staff tidied children’s books and toys away at the end of each day and we were told that the toys were deep cleaned monthly and wiped down on a daily basis. The staff on duty in the paediatric area took equal responsibility for this task.

Staff cleaned clinical areas between patients; waiting area floors and seating were in good order. During our inspection in March, we observed that the paediatric waiting room chair was in a very poor state of repair, which would have prevented effective cleaning. We immediately raised this to the trust executive team. The trust told us that replacement chairs were already on order but had not been delivered due to supplier delay. When we returned to the hospital mid-April, the trust had taken prompt action and managers had replaced the chairs.

Patient toilets were clean. We found that the environment was compliant with infection prevention and control guidelines and there was no dust below, or on top of surfaces. Cleaning staff were very thorough.

The department scored 98.6% for cleanliness in the Patient-Led Assessments of the Care Environment (PLACE) for 2017.

Staff used labels on equipment to identify when items had been cleaned and were ready for use.

From our previous inspection, we found that some staff did not follow appropriate hand hygiene procedures. Data sent to us from the trust showed that staff compliance had improved in early 2018 after deterioration in late 2017.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>NS</td>
<td>100</td>
<td>90</td>
<td>90</td>
<td>100</td>
<td>90</td>
<td>NS</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

The non-submission of data in July 2017 and January 2018 was explained as ‘audit staff on leave had not handed over to colleagues to undertake the audit’: Managers took action to ensure this would not happen in future.

All staff wore scrub style uniforms, which meant that staff observed the ‘bare below the elbow’ National Institute of Health and Care Excellence recommendation CG139.

Personal protective equipment (PPE), including gloves and aprons, were readily accessible in each separate area of the emergency department. We observed that medical and nursing staff used PPE when completing clinical tasks. We also observed that staff washed their hands and used hand gel when they left or entered the emergency department. All staff had personal gel bottles attached to their uniforms at all times.

Patients we spoke with in the emergency department also confirmed the high standard of cleanliness of the area they were using and that staff washed their hands when they arrived to examine them.

Environment and equipment

The design, maintenance and use of facilities and premises generally met most patients’ needs. There were systems and processes in place to ensure that the maintenance and use of equipment kept people safe.

The service had suitable premises and equipment, which staff maintained well.

The emergency department was appropriately designed, and well laid out, to allow for easy access, circulation and good lines of sight. There was a dedicated ambulance entrance, which
was a short distance from the ambulance parking bays and the helipad. This enabled quick and easy access to the resuscitation and major treatment areas.

The adult waiting area was visibly clean and included adequate seating. Male and female toilets were available and were clean. The toilet doors were designed to open both ways and the colours made for easy recognition by those with dementia. There was a baby changing facility in the female toilet only. This meant that fathers or male visitors to the department would not have access to dedicated baby changing facilities within the department.

Well-stocked vending machines provided access to drinks and snacks, although at the time of our visit the vending machine was out of order. Patients were able to get refreshments from other outlets nearby, and water was readily available.

The clinical environment was laid out in separate well-defined areas. This included a main reception, which afforded mostly direct viewing of patients from the reception desk. A triage room was off the reception. The area used for minor treatment led off from reception; this included a room for children easily accessible from the children’s waiting area, without the need for transfer through the adult area. The children’s area had child friendly murals, toys and posters to make it less clinical for child visitors.

The resuscitation area was directly accessible by ambulance teams and consisted of three bays. Each bay contained identical equipment trollies. Staff topped up regularly used equipment daily from the medical equipment library. Managers ensured equipment was serviced and maintained in line with manufacturers’ guidelines, and there were maintenance contracts in place. To ensure accuracy, equipment was regularly calibrated. We saw there were sufficient supplies of all equipment, and that disposable equipment for use in the department was properly stored and in-date.

We checked resuscitation equipment during our inspection. All trolleys were ready for use in an emergency and there were records in place to show that staff checked trolleys regularly in line with the hospital policy.

On the first day of our inspection, we saw that some of the cupboards in one of the treatment rooms were not closing properly and therefore not locking. Following our report to the staff, the issue was escalated to the estates team who adjusted the door fittings so the cupboards could be properly locked.

During our evening inspection, we saw some oxygen cylinders were not stored securely; the next day we learned that these belonged to a local ambulance service and were collected the following morning.

The area used for ‘major’ patients was overseen directly by the nurse/doctor station.

Rapid Assessment and Treatment area (RAT) bays consisted of four chairs and two cubicles with separate sides for men and women. At the time of our inspection, this area was very busy and staff utilised rooms flexibly while maintaining the privacy and dignity of the patients. This area is open between the hours of 10am and 10pm.

A mental health assessment room was available which met best practice standards as published by the Psychiatric Liaison Accreditation Network (PLAN). PLAN works with services to assure and improve the quality of psychiatric liaison in hospital settings.

There were two doors to the room, one of which opened inwards and one that opened outwards. This meant that staff had an escape route should the patients become agitated or aggressive. The door that opened outwards meant that patients could not barricade themselves in the room. There
were viewing panels in both doors to allow for observation of the patient; however, there were no privacy covers on the windows. This meant that other people could easily see into the room. There was adequate lighting in the room. There was a panic alarm strip around the inside of the room. There were three chairs in the room; however, one chair was not suitable for the environment as it was lightweight and could easily have been thrown or used as a weapon or a barricade. Staff told us that the chair was not usually in there and immediately removed the chair from the room. There were no ligature points other than the doors themselves, which opened onto busy corridors, which reduced the risk of patients attempting to ligature in that environment.

Assessing and responding to patient risk

Reception staff booked the walk-in patients and asked them to sit in the waiting area before triage by a designated nurse.

The triage process that we witnessed for both a child and an adult included a detailed assessment of the presenting problem, along with other initial information necessary for deciding the most appropriate pathway through the department. The trained triage nurse gathered information, including the record of the patient’s physiological observations on a National Early Warning Score (NEWS) or for children Paediatric Early Warning Score (PEWS).

At the time of our inspection, the trust had been piloting the NHS–E triage project using ‘Luton criteria’. This front door streaming project involves collaboration between ED staff and general practitioners using best practice protocols to ensure patients receive the care that they need, and performance against the four-hour standard improves, whilst also making sure that those patients whose needs are best served by a GP can go straight there.

The ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment so a team was waiting for them on arrival. The stroke outreach team were in the department every day and available until midnight for support. They checked the patient records and thrombolysis sets on a daily basis.

Patients brought in by ambulance came into the majors or directly into resuscitation via the direct ambulance route. Patients received in the majors area were booked in and assessed in the Rapid assessment and Treatment Hub (RATS).

A database was accessed which recorded ambulance timings including time of arrival and handover to staff.

Staff used a risk-based assessment process known as SBAR, which included considering the patients situation, background, assessment and recommendations. They also continued to monitor the condition of their patients using the early warning score system (NEWS).

There were processes to ensure patients were safe where their condition indicated specific treatment and care.

A sepsis policy was available to support staff in identifying and responding to patients with clinical indications of sepsis. The trust had developed a tool to identify in-patients who trigger the criteria for high-risk sepsis; they use this tool to audit the delivery of antibiotics within 1 hour of admission/diagnosis. They were adapting the identification tool to EWS ≥5 with known or suspected sepsis in line with nationally suggested guidelines. The most recent data available showed that 72% of patients received antibiotics within 1 hour of arrival in RBCH compared with the national average of 44%.
We observed good escalation processes following patients with increasing NEWS scores and 24-hour access to the critical care outreach team. The department met Royal College of Emergency Care (2017) quality standard with regard to timely access to a senior doctor where a patient’s condition warranted this.

Staff referred older people who attended the emergency department to the older peoples’ assessment and liaison specialists (OPAL) when appropriate. The OPAL team was a team of specialist healthcare professionals based in the emergency department who were able to make rapid assessment of the needs of elderly people who may have fallen or collapsed and may need help and support either during their hospital stay or to return home.

We saw that there was enough staff, so that, if required, patients could be escorted to receive a scan or x-ray.

Staff responded appropriately to patients presenting with risks associated with mental disorder or distress. Staff told us that the triage nurse assessed patients and if they identified a mental health condition, a ‘MH triage risk matrix form’ was completed. The form identified what level of risk the patient posed; the risk levels were colour coded in four bands, each band identifying a level of risk, and described the risk behaviours. Each band had a set of actions, which form the risk management plan. As a minimum, patients with a mental health condition were seen in ED on an hourly basis; however, this may be more frequent depending upon the risk. Staff told us that the medical staff would then see the patient, before they made any referral to the psychiatric liaison team.

We observed that the form was not being consistently completed quickly enough, meaning that for a number of hours, patients did not have a risk management plan in place and were not being monitored sufficiently.

Staff told us that the psychiatric liaison team were very accessible and had good rapport with the ED team.

Emergency Department Survey 2016

The trusts scored ‘about the same as’ other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Median time from arrival to initial assessment (emergency ambulance cases only)
The median time from arrival to initial assessment was better than the overall England median over the full 13-month period from January 2017 to December 2017. In the latest period, November 2017 the median time to initial assessment was one minute compared to the England average of seven minutes.

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

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

From January 2017 to December 2017, the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Bournemouth Hospital fluctuated between 53-63%. In the latest period, December 2017 63% of ambulance journeys had turnaround times over 30 minutes.

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

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

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From January to December 2017, the trust reported 105 ‘black breaches’.

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)
For the year prior to our inspection in 2015, the department had reported 252 black breaches; there was a significant improvement for the year prior to our inspection on this occasion, the number of black breaches had reduced by over 58%

**Nurse staffing**

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

The following HR information includes staff from The Royal Bournemouth Hospital emergency department.

The trust reported their registered nursing staff numbers as below as of November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post – November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal Bournemouth Hospital</td>
<td>180.6</td>
<td>175</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>180.6</strong></td>
<td><strong>175</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Emergency department shift patterns can be broken down into early, long day, late, twilight, night shifts.

The department used the ‘safer staffing’ tool to calculate their nursing staff requirements. The Safer Nursing Care Tool is an evidence-based tool that allows nurses to assess patient acuity and dependency and to use this to inform the number of staff needed.

At the time of our inspection, the nurse staffing was sufficient to provide the care needed for the patient numbers and acuity. The department nurse managers used agency staff and healthcare assistants flexibly providing appropriate skill mix to meet the need. Staff told us that they were able to work extra shifts to fill gaps that may arise at short notice.

The paediatric nursing team consisted of one band 7 nurses, 1 band 6 nurse, and two band 5 nurses. At the time of our inspection, there was one band 5 nurse on long-term sick leave and there were two vacancies at band 5 and one at band 7. This staffing level did not meet the Royal College of Paediatrics and Child Health (RPCPH) guidance and was on the department risk register. The trust had tried to recruit but found they had received a limited response due to the small size of the children’s service at this trust.

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a vacancy rate of 10% in urgent and emergency care at The Royal Bournemouth Hospital. Please note, the trust did not provide an overall target for vacancy rates.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a turnover rate of 6% in urgent and emergency care at The Royal Bournemouth General Hospital. This is worse than the trust target of 1% or less.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a sickness rate of 5% in urgent and emergency care at The Royal Bournemouth General Hospital. This is worse than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to October 2017, the trust reported an overall number of 21,016 shifts in urgent and emergency care at The Royal Bournemouth General Hospital. Of these shifts:

- 3,581 were filled by bank staff
- 113 were filled by agency staff
- 740 were not filled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The trust provided the shift patterns and use of agency staff for the winter months leading up to our inspection.

The shift patterns for the agency staff cover were as follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
<td>1</td>
<td></td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Long day</td>
<td>9</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Late</td>
<td>9</td>
<td>13</td>
<td>27</td>
<td>19</td>
<td></td>
<td>68</td>
</tr>
<tr>
<td>Twilight</td>
<td>3</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Night</td>
<td>10</td>
<td>8</td>
<td>20</td>
<td>20</td>
<td>10</td>
<td>68</td>
</tr>
<tr>
<td>Grand Total</td>
<td>29</td>
<td>9</td>
<td>44</td>
<td>57</td>
<td>58</td>
<td>197</td>
</tr>
</tbody>
</table>
Medical staffing

The trust reported their staffing numbers below as of November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post – November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal Bournemouth Hospital</td>
<td>73.1</td>
<td>69</td>
</tr>
<tr>
<td>Total</td>
<td>73.1</td>
<td>69</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From Monday-Friday, there is access to a Consultant 24 hours a day. One Consultant working on-site until 10pm.

The emergency department provided the following data relating to their consultant grade medical staff:

Prior to April 2018 there were nine consultants providing 7.2 whole time equivalent (WTE) cover.

From Monday to Friday, there was a minimum 24-hour Consultant cover; one consultant working on site until 10pm; after which the consultant remains on-call until 8am the next day. There was Consultant cover 8am-5pm Saturday and Sunday.

The team have been successful in recruiting three more consultants.

From April 2018, the department introduced an annualised rota, which included 12 consultants in post (10.6 WTE). From Monday to Friday, two consultants are available between 3pm and 10pm and consultants told us they were prepared to stay beyond this time according to the pressures in the department.

Staff told us the local deanery had recognised that the consultants in the department were in a position to supervise training in order to support Emergency Medicine Specialist Registrars. This means that the department will receive SpR trainees in 2019; subject to the number in training.

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a vacancy rate of 12% in urgent and emergency care at The Royal Bournemouth Hospital. Please note the trust did not provide an overall target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a turnover rate of 15% in urgent and emergency care at Royal Bournemouth General Hospital.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. From December 2016 to November 2017, the trust reported a sickness rate of 2% in urgent and emergency care at The Royal Bournemouth Hospital. This was better than the trust target of 3% or less. *(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Although the trust has not provided the total number of shifts required to fill for urgent and emergency care, the number of bank and agency staff used to fill shifts was as follows:

- 705 shifts were filled by bank staff
- 217 shifts were filled by agency staff
- 67 shifts were not filled.

*(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)*

**Staffing skill mix**

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

**Staffing skill mix for the 28 whole time equivalent staff working in Urgent and Emergency Care at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>32%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>26%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>9%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>33%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

*(Source: NHS Digital Workforce Statistics)*

Two middle grade doctors were appointed at the end of October 2017 which made the rota compliant initially but another vacancy arose from November.

Overall, the emergency department was staffed in accordance with guidelines issued by the Royal College of Emergency Medicine.
Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

Staff kept records related to patients at the nurse stations in the majors, minor and paediatric areas. In resuscitation where there was no nurse station, the staff at each bay managed them. In this area, where patients were so unwell, the notes were constantly in use.

Staff entered patient details onto a computer system that showed how long people had been waiting and the investigations they had received. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure.

The system produced patient records in a paper format so that all healthcare professionals could record care and treatment using the same document. When patients left the department, staff scanned the paper record onto the computer system to allow access to records for patients who have previously attended the department. If the patient was admitted, a copy of these were sent with the patient to the ward and the record was then scanned and added to the computer system so it could be viewed if the patient was re-admitted.

Medicines

The service managed medicines safely.

Medicines were stored correctly in locked cupboards or fridges. Controlled drugs were appropriately stored and staff kept suitable records. Controlled drugs are medicines, which require extra checks and special storage arrangements because of their potential for misuse. Medicines stored in fridges were stored at the correct temperature at the time of our visit. Staff maintained records to show that they regularly checked fridge temperatures.

We observed staff administer intravenous fluids safely and correctly and they completed accurate details on the medication chart.

We looked at three medicine charts and records and found that:

- Staff had taken appropriate blood samples from patients and prescribed antibiotics prior to the commencement of treatment. In each case, the antibiotics were prescribed following appropriate treatment pathways. This was in line with the National Institute for Health Care Excellence Quality Statement 61 (QS61), statements 1 and 4 that require antibiotics to be prescribed in accordance with local formularies and microbiological samples to be taken prior to treatment.

- Medicines administered by ambulance drivers were clearly recorded and communicated to the ED staff as part of the handover process.

- Nurses confirmed medicine administration by signing and dating prescriptions, and where necessary, two members of staff confirmed the correct medicines prior to administering.

- We saw that staff recorded patient allergies or sensitivities.

The department had a rotation and checking process in place to ensure that medicines did not go out of date.
Incidents
Never Events

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

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

From January 2017 to December 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in urgent and emergency care, which met the reporting criteria set by NHS England from January 2017 to December 2017. These were both sub-optimal care of the deteriorating patient meeting SI criteria.

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017)

We reviewed the investigation reports following these incidents; these showed that staff had undertaken a thorough investigation and root cause analysis, which identified learning points for all staff, with a detailed action plan put in place.

The department had a band 7 nurse lead for incidents supported by two band six nurses. A consultant who is lead for governance supports this nursing team.

Staff we spoke with told us that they discussed serious incidents in their team meetings and were encouraged to read the full reports and recommendations to ensure they fully understood the action plans.

Band 7 sisters had a monthly whole day meeting where incidents and learning would form part of the agenda.

We saw the ‘huddle board’, which was updated and discussed daily during the handover periods. The board contained a brief update of any learning from incidents to raise general awareness for staff.

Staff were aware of their roles and responsibilities for the reporting and recording of concerns and near misses, and the need to report them internally and externally. We saw that staff discussed incidents as they occurred and took measures to prevent reoccurrence.

The number of incidents reported in the emergency department between April 2017 and March 2018 were as follows:
<table>
<thead>
<tr>
<th>Incident Type x Severity</th>
<th>No Harm/Near Miss</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access, admission, transfer, referral, discharge</td>
<td>39</td>
<td>1</td>
<td></td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Communication and consent</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Confidentiality</td>
<td>3</td>
<td></td>
<td></td>
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<td>3</td>
</tr>
<tr>
<td>Diagnostic tests [not pathology]</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Equipment, resources, staffing</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Falls</td>
<td>13</td>
<td>4</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Medical and Non-Medical Devices</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Medication [incl. medical gases]</td>
<td>50</td>
<td>7</td>
<td>4</td>
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<td>61</td>
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<td>Pathology</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Patient accident [other than falls]/self-harm</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Patient Clinical Monitoring, Assessment &amp; Escalation</td>
<td>13</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Patient records</td>
<td>11</td>
<td></td>
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<td></td>
<td>11</td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>1</td>
<td>31</td>
<td></td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Security</td>
<td>2</td>
<td>6</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Staff incident</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Tissue Viability [non pressure ulcer]</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Transfusion</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Treatment, procedure, care</td>
<td>12</td>
<td>3</td>
<td>1</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Violence and aggression</td>
<td>20</td>
<td>13</td>
<td>1</td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>Grand Total</td>
<td>195</td>
<td>84</td>
<td>7</td>
<td>1</td>
<td>287</td>
</tr>
</tbody>
</table>

**Major Incident Training**

Staff training in major incidents is organised and run by two band 7 nurses once a month. The training takes the form of a table top exercise followed by scenario and role-play sessions. At the time of our inspection, there were training sessions in place until July 2018, all of which were fully booked.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer in December 2017, one fall in January 2017. There were no new catheter urinary tract infections from December 2016 to December 2017 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

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

The emergency department followed recognised evidence-based care and treatment guidelines, which were based on National Institute for Health and Clinical Excellence (NICE), and Royal College of Emergency Medicine (RCEM) guidelines. We saw that the ED staff had access to all professional policies and procedures.

We observed patient care, which reflected best practice, as outlined in the trust’s adult sepsis policy. Assessment and interventions of staff reflected the appropriate pathway and the patients’ treatment and care records were completed with the details.

The department participated in the national Royal College audits so it could benchmark its practice against other emergency departments.

Nutrition and hydration

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

The waiting room included well-stocked vending machines for people to access while waiting but at the time of our inspection, the machine was out of order.

A range of hot and cold foods and sandwiches were available to suit patients’ needs, including fruit and yogurt from outlets close to the emergency department, and staff told us they could access this whenever necessary.

Water fountains and squash was available for patients and their families where appropriate. Hot meals could be ordered by the department in order to meet patients nutritional needs.

Staff identified patients who were not able to eat and drink independently and provided assistance as required.

We saw that staff commenced intravenous fluids for many of the patients within the resus and majors areas; staff administered these through cannulas inserted into a vein. Nursing and medical staff maintained detailed accounts of the cannula insertion and fluids administered during the patient’s stay in the department.

Staff monitored fluid input and urinary output for patients when required.

Emergency Department Survey 2016
In the CQC Emergency Department Survey, the trust scored 6.9 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 7.2 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was better than other trusts.

The trust scored 8.1 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>7.2</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2016)

We saw pain relief offered to adults and children appropriately and according to need. For example, the paediatric nurse was able to give a small child in pain, liquid paracetamol from a locked cupboard. We saw that staff assessed adult patients’ pain using a scoring tool and offering analgesia when appropriate. Similarly, we observed a paediatric nurse using an age-appropriate pain scoring tool for a child aged 12 years.

Patient outcomes

The emergency department took part in the following national audits

RCEM Audit: Moderate and Acute Severe Asthma 2016/17

In the 2016/17 Moderate and Acute Severe Asthma report, the trust failed to meet any of the standards, which were all 100%. However, the trust scored higher or about the same as the UK average in all of the standards as set out below -

The trust was in the upper UK quartile for three standards:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Trust: 54%; UK: 26%.
- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). Trust: 33.3%; UK: 19%.
Standard 5b (fundamental): within 4 hours (moderate). Trust: 64.3%; UK: 28%.
The trust’s results for the remaining four metrics were all between the upper and lower UK quartiles:

- Standard 1a (fundamental): O2 should be given on arrival to maintain saturations 94-98%. Trust: 20%; UK: 19%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust: 26%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Trust: 77.6%; UK: 77%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as according to guidelines. Trust: 52.2%; UK: 52%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, the trust failed to meet any of the standards, which are all 100%.
The trust was in the upper UK quartile for one standard:

- Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Trust: 20%; UK: 10%.

The trust was in the lower UK quartile for one standard:

- Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Trust: 0%; England: 11%.

The trust’s results for the remaining two standards were both between the upper and lower UK quartiles:

- Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age. Trust: 20%; UK: 8%.
- Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Trust: 20%; UK: 12%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 severe sepsis and septic shock audit, the trust was in the upper UK quartile (and achieved significantly higher) for seven out of eight standards:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Trust: 88%; UK: 64.6%.
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Trust: 77.8%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. Trust: 100%; UK: 60%.
• **Standard 5:** Blood cultures obtained within one hour of arrival. Trust: 100%; UK: 44.9%.

• **Standard 6:** Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Trust: 74%; UK: 43.2%.

• **Standard 7:** Antibiotics administered within one hour of arrival. Trust: 72%; UK: 44.4%.

• **Standard 8:** Urine output measurement/fluid balance chart instituted within four hours of arrival. Trust: 56%; UK: 18.4%.

The trust’s result for the remaining metric was between the upper and lower UK quartiles.

• **Standard 1:** Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Trust: 58%; UK: 69.1%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Vital signs in children 2015/16**

In the 2015/16 Vital signs in children audit, the trust failed to meet four of the five standards.

The trust was in the upper England quartile for no fundamental standards and one developmental standard:

• **Standard 5** (developmental). Children with any recorded persistently abnormal vital signs who were subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). Trust: 100.0%; England: 60.0%.

The trust was in the lower England quartile for no fundamental standards and no developmental standard.

The trust’s results for the remaining five metrics were all between the upper and lower England quartiles.

• **Standard 1.** All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
  - **Standard 1a** (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU scores. Trust: 29.4%; England: 37.6%.
  - **Standard 1b** (developmental). Capillary refill time. Trust: 19.6%; England: 22.5%.

• **Standard 2** (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. Trust: 8.3%; England: 4.4%.

• **Standard 3** (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Trust: 83.3%; England: 69.7%.

• **Standard 4** (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Trust: 83.3%; England: 73.2%.

(Source: Royal College of Emergency Medicine)
RCEM Audit: Procedural sedation in adults 2015/16

In the 2015/16 Procedural sedation in adults’ audit, the trust failed to meet any of the audit standards (which were all 100%).

The trust was in the upper England quartile for none of the fundamental standards and none of the developmental standards.

The trust was in the lower England quartile for three fundamental standards and one developmental standard:

- Standard 1 (fundamental): Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
  - Standard 1a. ASA grading
  - Standard 1b. Prediction of difficulty in airway management
  - Standard 1c. Pre-procedural fasting status.
    
    Trust: 0.0%; England: 7.6%.

- Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  - Standard 4a. A doctor as sedationist
  - Standard 4b. A second doctor, ENP or ANP as procedurist
  - Standard 4c. A nurse
    
    Trust: 0.0%; England: 40.8%.

- Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area.
  
  Trust: 17.7%; England: 41.0%.

- Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  - Standard 7a. (fundamental): Return to baseline level of consciousness.
  - Standard 7c. (fundamental): Absence of respiratory compromise.
  - Standard 7d. (fundamental): Absence of significant pain and discomfort.
  - Standard 7e. (developmental): Written advice on discharge for all patients.
    
    Trust: 0.0%; England: 2.6%.

The trust’s results for the remaining three metrics were all between the upper and lower England quartiles.

- Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity had been recorded.
  
  Trust: 43.8%; England: 51.8%.

- Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities.
  
  Trust: 88.2%; England: 90.0%.

- Standard 5 (fundamental): Monitoring during procedural sedation must be documented to
have included all of the below:
- Standard 5a. Non-invasive blood pressure
- Standard 5b. Pulse oximetry
- Standard 5c. Capnography
- Standard 5d. ECG

Trust: 17.7%; England: 23.9%.
(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit, the trust met one of the two audit standards (which were all 100%).

The trust was in the upper England quartile for both of the standards:

- Standard 1 (fundamental): If a need for thromboprophylaxis was indicated, there should be written evidence of the patient receiving or being referred for treatment.
  Trust: 100.0%; England: 100.0%.

- Standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation.
  Trust: 19.2%; England: 2.0%.
(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From January 2017 to December 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average.

(Source: NHS Digital - A&E quality)
We saw evidence that the department conducted a rolling sepsis audit; neck of femur audit; and sedation audit, but the trust did not submit any results from these audits.

**Competent staff**

**There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs.**

All nursing staff must complete a competency logbook as part of their induction. For their first two weeks in post, they were not part of the establishment for the department and shadowed qualified nurses for support. The staff explained that they worked with a ‘buddy’ and individuals were encouraged to say if they were not confident to work independently after two weeks and the induction could be extended for a reasonable length of time.

The department manager at the time of our inspection told us that they considered training key to keeping up staff morale and as far as possible developmental skills training would be maintained even when the department was busy. For example, the plaster training took place during our visit even though the service was busy and at the highest level of escalation.

A recent action-learning week included a session on the ‘Fit 2 Sit’ campaign. This follows the concept of ending ‘PJ paralysis' and starts in the emergency department, where staff can do their bit to stop deconditioning in patients from the moment they enter the hospital, encouraging patients to be seated during their time in the department, rather than lying on a trolley.

All band 5s in the emergency department completed key skills training. The facilitator collected feedback from these sessions and adjusted the training according to the feedback received. For example, following the recent training sessions they adjusted the content to include a ‘deteriorating patient’ scenario, which included more in-depth information beyond the initial assessment of the patient.

We spoke with a nurse practitioner who was soon to start advanced nurse practitioner (ANP) training. This training had the potential to increase numbers of ANPs to cross cover the majors and minors areas. The medical team fully supported this development.

We spoke with a healthcare assistant (HCA) in the department who explained that they were trained in 11 different plasters and they were able to cannulate patients and to undertake venesection.

The HCAs had a wide scope of practice, which included personal care, wound care, and stock management.

All non-training doctors had an appraisal and completed the revalidation process. Clinical supervision forms part of the process of appraisal and revalidation. All named clinical supervisors received additional training for this role. The trust had a process in place that all education and supervision was signed off by the trust's education lead prior to an appraisal.

We were told the psychiatric team provided three hours per month training to staff in the emergency department and staff said they have found this useful. Consequently, emergency department staff were comfortable approaching the psychiatric team for advice.

Staff were trained in supporting and managing patients who were potentially aggressive in manner. At the time of our inspection, a security guard supported the staff in the ED between the hours of 8pm and 8am 7 days per week; and on Saturday and Sunday there was a security guard
24 hours per day. The staff told us that all the clinical staff in the emergency department attended 'breakaway' training, where they learn techniques to protect themselves from aggressive patients and de-escalate potentially dangerous situations. We learned that the porters also received this training. Basic conflict resolution also formed part of the nursing staff mandatory training programme, and at the time of our inspection, 90% of them had attended this training.

**Appraisal rates**

From December 2016 to November 2017, 91% of staff within urgent and emergency care at the trust had received an appraisal compared with the trust target of 90%

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>39</td>
<td>41</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>141</td>
<td>154</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>145</td>
<td>163</td>
<td>89%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

We observed a multidisciplinary approach to the review of activities and patient case mix, with staff sharing up to date information in a clear manner.

Staff had good working relationships with other staff and disciplines within the hospital and trust. This included staff from medical and surgical specialities, psychiatric liaison, critical care outreach and the stroke team. Nursing staff told us they had good relationships with consultants and doctors of different disciplines. We observed the senior consultants leading the department, working closely with the nursing staff and senior managers to facilitate patient care and flow.
Staff, reported working well as a team and that communication was generally good. A registrar who spoke with us told us there was good multidisciplinary team working. This included assessing, planning and delivering care to patients, and effective handovers.

We attended two bed meetings, which considered the activity within the ED, and the flow through the hospital. These meeting were extremely effective, efficient and attended by key representatives from the department and from the rest of the hospital.

We also observed and spoke with ambulance staff who provided patient transport services as they liaised with nursing and support staff to support the effective discharge of patients from the department.

Child and Adolescent Mental Health Services (CAMHS) were available for assessment from 9am to 9pm. After 9pm, children up to the age of 15 would be taken to the designated paediatric emergency department in another hospital in the region and those who were 16-19 years were sent to an observation ward overnight until review the next day.

**Seven-day services**

The service was open 24 hours a day seven days a week. The service included, or had access to, the full range of investigative and diagnostic procedures, pharmacy, specialist doctors, nurses, and allied health professionals 24 hours a day, seven days a week. However, there were insufficient numbers of paediatric nurses available to cover 24 hours seven days per week. This meant children and young people would, at times, be assessed and treated by adult nurses.

Our observations of patient records, discussions with staff and review of policies confirmed that the service met NHS England’s seven-day services priority standards:

- **Standard two** - (all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible and within 14 hours of arrival at the hospital).
- **Standard five** - (hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology).
- **Standard six** - (hospital inpatients must have timely 24-hour access, seven days a week, to consultant-directed interventions.)

Chest physiotherapy was available seven days a week via the on-call team and they attended patients who required Bilevel Positive Airway Pressure (BiPAP). This is a non-invasive form of therapy for patients needing pressurised air through a mask to keep the patient's airways open.

The consultants in the emergency department told us that to improve cover in the department the consultants had agreed to increase frequency of weekends and to double up to 18 hours of cover during the weekend, allowing cover up to 10pm seven days a week.

**Health promotion**

The department had systems and processes in place to ensure that people who may need extra support around health promotion were identified and provided with support. For example, the older people’s assessment and liaison (OPAL) specialists. This team worked closely with outside agencies to ensure that patients leaving the department were looked after so promoting better health amongst those vulnerable patients who had visited the department.
There were a number of patient information leaflets available across the department, advising patients who attended the department; for example on care following injury, appropriate exercises and wound care. We observed children and their parents being given very clear discharge information following a head injury. This included information about self-care and when to alert for extra support.

We saw posters displayed in the department around health promotion so that patients were supported and encouraged to manage their own health; such as posters about weight loss and leading a healthier life.

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

Staff understood the importance of consent when delivering care and treatment to patients, displayed a good understanding of the requirements of the Mental Capacity Act (2005), and knew where to obtain expert help, such as from the consultants or the psychiatric liaison team.

The Trust had a policy for the Mental Capacity Act (MCA), which provided guidance to staff on the assessment of capacity involving care and treatment decisions. This included guidance on the use of Deprivation of Liberty safeguards for those patients that do not have capacity to make the decision to remain in hospital to receive care.

We saw the guidelines on the intranet relating to MCA. Staff told us that they occasionally detained patients under the deprivation of liberty safeguards (DoLS) and if they had concerns about capacity, they would ‘escalate to the consultant of the day, and document concerns in the patients notes.’ However, as most patients did not stay long in the department staff rarely made DoLS referrals.

We observed staff routinely obtained consent for treatments and procedures undertaken throughout our inspection. In the care of children, we observed both child and parents being asked to consent to the procedure.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff received training in dementia awareness and dementia tier 2 on the annual training days, but this did not include training in the Mental Capacity Act (MCA).

**Is the service caring?**

**Compassionate care**

We were impressed with the consistently compassionate care staff delivered within the department, even when the trust was at the highest level of escalation, and had declared a major internal incident at the time of our inspection. Staff were friendly, professional and helpful to patients. Staff used humour when it was appropriate, and were respectful of all patients’ individual preferences, habits, culture, faith and background.

Staff were compassionate and helpful to patients in all interactions; we saw that they wore ‘Hello my name is’ badges and we observed they spoke about their patients in a caring and compassionate manner, and respected patients’ dignity at all times, including when the ED was very busy.
We observed staff treating children with patience and compassion to put them at ease. We observed a consultant provided care to a child and they were exemplary in their approach. They knelt to the patient’s height, spoke in a child friendly manner but also afforded the child choice and control within their situation. The consultant applied the same care and consideration to the child’s mother.

Receptionists were warm and friendly when assisting all patients during the booking in process. Patients we spoke with consistently gave positive feedback about their experience in the department. They told us that staff were courteous, respectful, and regularly checked with them about their comfort and wellbeing. They also said that staff treated them with kindness and compassion.

**Friends and Family test performance**

From December 2016 to November 2017, the trust’s urgent and emergency care friends and family test performance (% recommended) was generally better than the England average. In the latest period November 2017, performance was 94.5% compared to the England average of 86.9%. Friends and Family data ranked 8th out of 138 Trusts in January 2018, placing this Ed in the top 10%. (National data)

Staff we spoke with valued the friends and family test results and were keen to improve patient experience where possible. Recommendations by staff as a place to receive treatment were consistently above the national average.

**A&E Friends and Family Test Performance - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust**

(Source: NHS England Friends and Family Test)

Information relating to the friends and family test was displayed for patients.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress. Patients were very happy with the care and support they were receiving**

In the contact with patients we observed, it was apparent that both medical and nursing staff understood the emotional impact of the patients’ care and treatment potentially had on the overall wellbeing of patients and their relatives.
We observed that staff provided appropriate and timely support to help patients cope emotionally with their care and treatment. Staff advised patients about how to access other support services and they offered this advice as early in the patient pathway as appropriate.

The staff prioritised patients according to their clinical condition; for example, patients who were distressed or with a mental health condition were seen quickly following triage.

The emotional support provided by staff included the carers, family and dependants of patients attending the emergency department.

A chaplain was available to the department for spiritual and emotional support if required.

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

Staff involved patients and those close to them in decisions about their care and treatment. Patients were very happy with the care and support they were receiving.

Staff were approachable and happy to talk with patients and their relatives about any concerns or anxieties. We saw that staff were friendly when speaking to patients and their relatives taking time to talk about topics other than their health, if in the department for any length of time.

We saw that relatives generally accompanied patients attending the department. Doctors and nurses spoke with relatives to identify any additional information, which may contribute to identifying the patient’s condition. We saw that relatives regularly contributed to the details of the patients' history during inspection.

Staff were able to contact the patient’s GP for further clinical history, and they had good access to local community mental health teams to provide information on patients known to them.

Throughout the inspection, we saw that staff spoke kindly to distressed patients. Relatives of patients treated in the resus area were kept informed and encouraged to visit the patients when interventions were not taking place.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 22 of the 24 questions relevant to caring. The remaining two questions both scored better than other trusts.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>5.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>information about your condition or treatment was given to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>medical or nursing staff to help you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>and another will say something quite different. Did this happen to you</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your care and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>dignity while you were in the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>treatment, did a doctor or nurse discuss them with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q24. If you were feeling distressed whilst in the emergency</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>department, did members of staff help to reassure you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>of your tests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>medications you were to take at home in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>effects to watch out for?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>usual activities, such as when to go back to work or drive a car?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>account when you were leaving the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>regarding your illness or treatment to watch for after you went home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried</td>
<td>8.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>about your condition or treatment after you left the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2016)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people. Facilities and premises were appropriate for the services that managers and staff planned and delivered. Patients entered the emergency department via two entrances, one for patients brought by ambulance, the other for self-presenting patients. Self-presenting patients checked in at the main reception desk, where their privacy and dignity were protected.
There was a large waiting room, which provided adequate seating for patients and visitors during our visit.

There was some reading material provided. Patients and visitors had access to drinking water and other drinks and snacks were available in vending machines.

There were male and female toilets and toilets adapted for wheelchair users, and nappy changing facilities were available in the female toilet.

There was a range of information available to patients and visitors about where to seek support, including alternatives to visiting the minor injuries service in the emergency department. Some of the patient information leaflets about common clinical conditions were available in a variety of languages, and staff told us that they were able to use a translation service for patients who required a language that was not readily available on the racks.

The department had changed the way patients were triaged and streamed around the ED since our last inspection. They were piloting a modified Luton and Dunstable triage system in collaboration with local GPs, which we observed to be efficient, and improved the patient experience.

Patients’ pathways were evidently considered in service planning and design. For example, the department had good signage to direct patients to the appropriate area of the ED such as the x-ray department.

**Emergency Department Survey 2016**

The trust scored “about the same as” other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Meeting people’s individual needs**

The service took account of patients’ individual needs. We saw that patient needs were assessed and appropriate equipment used to ensure patient safety.

Staff assessed patients on admission to the department using forms that enabled them to capture key information relating to the patient’s condition and medical history and to monitor clinical observations. The initial assessment enabled staff to identify any long-term conditions or complex medical history details, which would affect the ability to treat or discharge the patient. For example, elderly patients who lived alone, and admitted following a fall, were referred to the OPAL team for additional assessment and support.

Staff could access translation services via the hospital switchboard if required for patient whose first language was not English. Post inspection the trust told us they held a multi-cultural staff mix speaking a variety of languages. This information was stored on central database and utilised to
aid personal interactions. Staff could also access a wide range of spiritual support for patients from a range of cultural background through the hospital chaplaincy service. We visited the hospital chapel, which was non-denominational. It was an inviting and well-resourced environment. There were appropriate washing facilities for those attending the chapel that required them such as practising Muslims. We were told free car parking tickets are provided for patients who are in the department a long time, or relatives who are bereaved or similar.

Staff were able to seek support from the dementia and learning disability (LD) lead nurses for the management of patients with these conditions. Nursing staff told us that the lead nurses were easily accessible and attended the department regularly. The trust provided training for dementia and learning disabilities awareness, with additional training provided for dementia and LD champions. The trust had an internal flagging system for patients with a learning disability, which enabled staff to quickly identify and plan appropriate adjustments or support if required. Staff could describe adjustments they had made to support patients with learning disabilities; for example, one paediatric nurse described creating a lower sensory environment as practicable for a child with severe autism.

Emergency services were delivered and co-ordinated to be accessible and responsive to patients with complex needs. Staff supported patients during referral; transfer between services, and at discharge. Senior medical and nursing staff in the department coordinated patients’ involvement with carers and relatives, particularly for patients with long-term conditions.

Staff could access timely support for patients with mental health needs through the psychiatric liaison team. The local mental health trust provided this team, but we observed positive regard across the ED staff for the liaison team. For patients with mental health needs not requiring urgent assessment, staff knew how to contact the relevant community mental health team. There were dedicated alcohol nurse specialists within the department to support patients with potential alcohol misuse or dependence.

Access and flow

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for four months over the 12-month period from January 2017 to December 2017. In the latest period, December 2017 the median total time to treatment was 75 minutes compared to the England average of 62.0 minutes. The trust reported that December 2017 was a particularly busy month at the hospital.

The department had introduced ‘fit to sit’, and where appropriate, patients could wait in a waiting area after initial assessment. This ensured the patients were more comfortable and a better patient experience was achieved.

Staff told us that if a patient did breach the four-hour indicator in the emergency department, the operational manager would try to address the issues causing the delay. If any patient was in the department for four to six hours, staff would check they were on an appropriate bed, check diet and nutritional needs, as well as pressure areas as part of the daily comfort round.
Ambulance – Time to treatment from January 2017 to December 2017 at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

The trust met the standard four times from January 2017 to December 2017.

The trust breached the standard eight times from January 2017 to December 2017.

This performance was consistently better than the England average but below the national standard.

Four-hour target performance - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Percentage of patients waiting between 4 and 12 hours from the decision to admit until admission

From January to December 2017, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust’s monthly percentage of patients waiting between 4 and 12 hours from the decision to admit until admission to a ward was better than the England average. Performance against this metric showed a trend of decline over the period until November 2017.
Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust


Number of patients waiting more than 12 hours from the decision to admit until admission

Over the 12 months from January to December 2017, no patients waited more than 12 hours from the decision to admit until admission to a ward.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between four and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2017</td>
<td>258</td>
<td>0</td>
</tr>
<tr>
<td>February 2017</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>March 2017</td>
<td>98</td>
<td>0</td>
</tr>
<tr>
<td>April 2017</td>
<td>66</td>
<td>0</td>
</tr>
<tr>
<td>May 2017</td>
<td>114</td>
<td>0</td>
</tr>
<tr>
<td>June 2017</td>
<td>79</td>
<td>0</td>
</tr>
<tr>
<td>July 2017</td>
<td>98</td>
<td>0</td>
</tr>
<tr>
<td>August 2017</td>
<td>63</td>
<td>0</td>
</tr>
<tr>
<td>September 2017</td>
<td>72</td>
<td>0</td>
</tr>
<tr>
<td>October 2017</td>
<td>87</td>
<td>0</td>
</tr>
<tr>
<td>November 2017</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>December 2017</td>
<td>206</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From January to December 2017, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average.

Percentage of patient that left the trust without being seen - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
From January to December 2017, the trust’s monthly median total time in A&E for all patients was consistently similar to the England average.

In Jan 2017, the trust’s monthly median total time in A&E for all patients was 143 minutes, which was lower than that of the England average, which was 154.

Since our previous inspection in 2015, the trust had improved the patient escalation processes. During this inspection, we attended two bed meetings, which we observed to be efficient and well run. The emergency department lead operational nurse presented the status of occupancy within their department and matrons and other key staff from the rest of the hospital did likewise. The attending team were able to identify potential discharges and transfers, which supported the ED team to prioritise and manage the flow of patients for admission. During the inspection, The Royal Bournemouth Hospital was at Operation Pressures Escalation Level 4 (OPEL). This is the highest level of alert.
The NHSE South Central OPEL Framework is the on-going means by which the system aims to collectively manage any sudden and unpredictable surges in activity influencing the balance of demand over capacity in key services.

The trust had introduced a number of effective measures to improve patient flow through the hospital system; for example; streaming to direct patient to the most appropriate care setting, ambulance assessment, direct access to the rapid assessment team. Each of these received different types of patient with the aim of reducing the burden on the department, enabling them to see patients quickly and efficiently in the right place at the right time.

It was evident from our observations during the inspection that all ED staff and ambulance paramedic staff understood the escalation procedures in place and worked flexibly to respond to the needs of all patients in their care.

Learning from complaints and concerns

The emergency department had a senior nurse complaints lead who explained that the department receives informal and formal complaints directly, and some via the patient advice and liaison service (PALS). Data showed that approximately 80% of the complainants received a response within the agreed trust timescales. The trust were reviewing their complaints target timeframes as they recognised some complaints take longer as they are more complex or required more detailed investigation. Staff received on average five complaints a month, about half of which were informal. Themes included, for example, misdiagnosis and communication. Actions and learning from complaints were shared with staff at the daily huddle or through team meetings; the department newsletter also carried entries about complaints.

A recent complaint involved a patient who had attended the department; and was under the care of the trust colorectal team. The colorectal nurse specialist worked closely with the surgical team and the ED team to reach an acceptable resolution and response for the patient.

Is the service well-led?

Leadership

The directorate had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The emergency department was supported by a leadership team as part of the medicine directorate (ED, AMU, medical specialities), which was one of three directorates (older people’s medicine, cardiology and medicine) within care group B.

Medical and nursing staff spoke extremely positively of the management arrangements in the emergency department and of the clinical leadership. There were very strong positive relationships between managers and staff. At the time of our inspection, there was an established nursing sister in charge until a new matron took up her post.

Staff told us leaders were reliably visible, up to and including executive level and we observed that to be the case. One member of staff told us the consultants were ‘really helpful’ and the department was one of the best places they had worked.

We observed the clinical leadership and strong nursing leadership functioning in the department and managers interacting, helping and supporting staff.

The trust had formulated a ‘people plan’ in 2017, which identified the staff planning priorities until 2020. There were eight priority themes, which included leadership and management; the trust had recently introduced a new leadership strategy and model.
The organisational development team in the trust delivered bespoke leadership training for the care group leaders and a matron’s development programme. During our inspection, we observed strong and focussed leadership within the department and at trust level supporting the team to continue to deliver a high standard of care to patients whilst they were at peak escalation level.

Vision and strategy

The trust had a vision for what it wanted to achieve, and workable plans to turn it into action.

The trust was working with local partners to prepare for a planned merger with the neighbouring NHS trust.

The vision and strategy for RBCH was evolving and developing following the recent clinical services review within Dorset. The trust’s vision from January 2018 was to ‘work in partnership and continually improve services’

Staff we spoke with confirmed the vision, strategy and the key priorities for the department matched those of the overall clinical strategy, in providing quality care and collaborative working.

Staff were committed to realising the trust’s vision and delivering successfully restructured services in East Dorset. We saw lots of evidence of partnership working between the two emergency departments; for example shared clinical protocols for paediatric care and treatment.

Culture

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

During our inspection, there was an overwhelming sense of teamwork and support for each other amongst all staff. Staff consistently reported feeling happy in their work and we observed a highly person-centred culture.

Many staff told us how, since the last inspection there had been away days and listening events, including access to trust executives which had resulted in an improved feeling that staff were listened to more than ever before.

The culture within the department was observed to be exceptionally person-centred. During our inspection, the trust were at the peak escalation level, indicating critical capacity concerns, but we observed staff to be highly motivated and working together for the benefit of patient care. Whilst the department was busy, we were impressed that staff worked hard to ensure that patients were protected from the stress faced by the staff team at that time. Staff presented as warm, welcoming and engaging whilst being focussed on their work.

The Trust won a Health Service Journal staff engagement award in 2017 for its’ culture change programme for empowering staff to provide compassionate and high quality care for patients, enhancing staff experience and achieving a positive response.

Staff talked about the change champion initiative developed by the trust organisational development team; their work included listening to staff about how they want to be recognised, which led to the first ‘#Thank you! Day’ attended by more than 1,100 members of staff; introducing a simplified and inclusive approach to trust objectives; and bringing in a new training programme on customer care. The emergency department were involved and it was evident during our inspection that the whole team had a drive to establish how they could work together to channel their new found sense of empowerment into improvements to benefit patients.
The trust appointed a freedom to speak up guardian (FTSUG) in April 2017. Staff we spoke with were aware of this appointment and told us that, as with other events, which had encouraged a feeling of openness, they would feel comfortable to approach the FTSUG with any concerns or issues.

Staff also told us that they would be confident to use the whistle blowing policy because they felt that the managers listened to them and would act on any reports.

Staff had access to support and a debrief was held after a traumatic situation. Counselling services were available for staff to access as well as support from peers and senior staff.

Some staff told us of the newly formed Lesbian Gay Bi-sexual and Transgender (LGBT) network at the trust and some wore rainbow badges to mark their support for the network. Staff reported the trust valued and celebrated diversity.

**Governance**

*Service leads used a systematic approach to improve the quality of its services, and to safeguard high standards of care, by creating an environment in which excellence in clinical care would flourish.*

The emergency department held regular governance meetings, which were attended by emergency nurse practitioners (ENPs) and emergency Care Practitioners (ECPs). Governance was led by the clinical lead for the service, another consultant who led on governance, the operational manager, and the new matron soon to join the trust would be part of that team when they took up their post.

The team told us that they held bi-monthly meetings, which focussed on clinical and risk issues. The outcome from these meetings fed into the trust Quality and Risk Committee (QARC) via the care group governance meetings.

The department’s lead for national and local audit was a consultant in emergency medicine. We reviewed the emergency department’s audit programme and timetable. The department followed a system of clinical audit for a range of pathways and operational situations within the department to monitor quality, including those used from the RCEM.

We saw minutes and agendas from the ED risk governance meetings (ED RaGG); issues regularly discussed included the risk register, safeguarding, mortality and morbidity (M&M), incident reporting, complaints and others as appropriate, such as ambulance queuing and medication safety, audit participation.

The ED produced a monthly safety newsletter; ED Snippets, which all staff were aware of and read; we saw several copies of this, which included for example; ‘child protection information sharing’ and the top ED risks.

**Management of risk, issues and performance**

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

The clinical governance structures within the emergency department, supported through the management team, provided assurance that systems were in place to manage and monitor
performance. We saw that managers escalated performance issues appropriately following departmental guidance. Plans were in place to manage both current and future performance; these were regularly reviewed.

The ED service leads used a performance dashboard to present performance information in a standardised and comparable way. Data on ED performance included: the 4-hour target, the implementation of primary care streaming for ED, ambulance handovers, review and further development and actions of escalation processes (OPEL)

We reviewed the emergency department’s risk register, which reflected current risks. The top risk entries as at February 2018 were:

- Ambulance Queues
- Follow-up of X-ray Reports
- ED Middle Grade Doctor Coverage
- Symphony Upgrade
- Urgent Care – Front Door and Flow
- Paediatric Vacancies

The risks on the risk register correlated to the top risks described by staff and were in line with our inspection findings.

The nurse lead for risk and incident management explained that staff were encouraged to report incidents, and when themes emerged, the risk leads implemented practice changes to reduce the risk of further occurrence.

We saw from minutes of the ED RaGG that staff discussed the risk register regularly along with potential mitigation to manage the risks.

It was evident that the measures and meetings were efficient and effective at managing department risks and performance.

**Information management**

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

The trust had mechanisms in place to review the quality of data used for external reports and internal and external benchmarking. There were robust measures in place to monitor and manage the performance of the department against local and national indicators, which managers observed closely.

Staff were able to access patient information using an electronic system and paper records. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. This meant that staff had information about the most up to date medications, health conditions and symptoms to enable them to make a better diagnosis and treatment plan. Ambulance staff could also share patient test results with the staff whilst on route to the department.

Nursing and medical staff in the emergency department could access key operational information on a live tracking system. We observed the dashboard, with patients presented in clinical priority order, and with status information including their length of stay in the department. The dashboard also included key operational information about the department. We observed use of the board where the care and treatment of patients was reviewed using the latest, live information. We
observed that both medical and nursing staff used the information presented to challenge constructively the basis of decisions made about patients’ care and treatment.

**Engagement**

**Service leads and managers trust wide engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**

Patients were encouraged to complete regular surveys to provide feedback on the trust performance. Themes of concerns and complaints and feedback of the friends and families test were scrutinised and the findings used to improve care. The department had introduced a text feedback system just prior to our inspection, which had improved the response rate for patient and relative feedback.

The ED team had developed a ‘bereavement pack’ in collaboration with the trust bereavement team and involved a patient’s mother. The team invited her to work with them in order that they could understand the concerns she had expressed following the death of her son following an accident.

The trust held an annual open event which patients, public, staff and governors were invited to attend.

One of the ED department consultants had introduced a ‘Happy App’ for staff that the clinical lead monitored. All staff could access this app, which gave them the opportunity to feedback, anonymously if they preferred, about many things, for example, team working, patient care, equipment.

Managers and clinical leaders also used the app for miscellaneous announcements, for example ‘room 6 in x-ray is closing for refurbishment’

The Friends and Family Test performance was measured and discussed regularly at the governance group meetings. Recent results showed that the department was recommended by 97.3% of patients in October 2017 and 91.4% January 2018.

**Learning, continuous improvement and innovation**

**Service leaders were committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.**

There was a culture of supportive learning and improvement embedded in the department, which extended to the training of new doctors and nurses. Several staff members told us they continued to work in the department following qualification because of the supportive culture.

Staff we spoke with reported feeling empowered to make improvements for the benefits of patient care in their everyday work. There was a firmly embedded culture of quality improvement within the department and across the wider trust. All staff felt the trust had mechanisms in place to ensure that good quality improvement ideas could be put forward, trialled, evaluated and shared if appropriate.

The pilot scheme for improved triage for ‘walk –in’ patients in collaboration with local GPs had improved patient flow and ensured that patients were seen by the right people in the right place.

Scenario skills training undertaken in the simulation suite, which replicates the department and involves staff at all levels in the ED as well as intensive therapy unit (ITU) consultants and others as appropriate.

Introduction of the Happy App for staff allowed the clinical lead to assess the mood and concerns of staff daily and act upon issues with immediate effect.
The administrative staff in the emergency department undertook a daily audit following the ‘SHINE’ project. This was an innovation to improve safety in emergency care undertaken by the University of Bristol in 2014.

Medical care (including older people’s care)

Facts and data about this service

The Royal Bournemouth and Christchurch Hospitals NHS Foundation trust has indicated that there are between 342 and 344 beds across 26 wards within medicine.

(Source: Routine Provider Information Request - Acute-Sites)

The trust had 53,576 medical admissions from October 2016 to September 2017. Emergency admissions accounted for 18,715 (35%), 3,065 (6%) were elective, and the remaining 31,796 (59%) were day case.

Admissions for the top three medical specialties were:

- General Medicine – 25,941 admissions.
- Clinical Haematology – 6,345 admissions.
- Cardiology – 6,016 admissions.

(Source: Hospital Episode Statistics)

During this unannounced visit, we visited the following medical wards and departments:
- Acute Medical Unit with 52 beds including five beds for patients with very acute needs
- Treatment Investigation Unit had 13 chairs, two single rooms and 10 beds.
- Medical Ward 1 gastroenterology with 22 beds including four acute beds
- Medical ward 2 respiratory with 26 beds including a four bedded acute lung unit
- Medical ward 3 respiratory, gastroenterology, endocrinology and general medicine with 28 beds
- Endoscopy
- Coronary care unit with 15 beds (six acute and nine stepdown).
- Ward 23 cardiac investigations unit, cardiac ward and medical outliers
- Ward 22 an acute 28 bedded cardiac ward with medical outliers
- Ward 26 a 25 bedded older persons assessment unit
- Ward 4 a 28 bedded older persons short stay ward
- Ward 5 a 28 bedded older persons ward for people with complex discharge planning needs
- Ward 24 a 25 bedded older persons short stay ward
- Ward 25 a 25 bedded older persons short stay ward
- Ward 11 a 15 bedded Haematology ward
- Stroke unit a 36 bedded ward including four high acuity beds.
- Ward 9 winter pressures ward with 23 beds (opened on 1 January 2018 and closed 28 March 2018).
- Discharge lounge with 11 chairs. Occasional patient in a bed taken within a dedicated space.

We did not visit the day hospital at Christchurch Hospital during this inspection.

Whilst we inspected the medical wards and departments the inspection team:
- Observed and spoke with 41 patients and 11 relatives.
- We received 89 comments cards
- Reviewed 26 individual records
- Observed and spoke with 101 different staff members including doctors, nurses, therapists, healthcare assistants, managers and non-clinical staff

The Care Quality Commission last inspected the hospital in 2015, and rated the medical directorates stroke services, older persons medicine and medicine as requires improvement Effective, responsiveness and well-led domains rated as good.

There were five requirement notices issued to the trust following the last inspection and a number of must and should actions for the trust to make improvements.

**Is the service safe?**

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

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

**Mandatory training**

The service provided mandatory training in key skills to all staff. However, compliance with the trust target was not achieved for any of the training modules for medical staff and partially met for nursing staff.
The trust set a target of 95% for completion of mandatory training. Staff we spoke with told us that some training modules were completed online and others face to face. Ward sisters and charge nurses told us that at times of high pressure for beds, training booked was cancelled and staff would then re-book training.

A breakdown of compliance for mandatory courses as of November 2017 for medical/dental and nursing staff in medicine at Royal Bournemouth Hospital is shown below:

### Mandatory training - medical staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>95%</td>
<td>188</td>
<td>204</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>192</td>
<td>209</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>187</td>
<td>205</td>
<td>91%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity &amp; Human Rights</td>
<td>95%</td>
<td>189</td>
<td>209</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Sharps-Level 2</td>
<td>95%</td>
<td>185</td>
<td>205</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>95%</td>
<td>188</td>
<td>209</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Security, Violence &amp; Fraud</td>
<td>95%</td>
<td>182</td>
<td>209</td>
<td>87%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>95%</td>
<td>179</td>
<td>207</td>
<td>86%</td>
<td>No</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>95%</td>
<td>177</td>
<td>205</td>
<td>86%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>180</td>
<td>209</td>
<td>86%</td>
<td>No</td>
</tr>
<tr>
<td>WRAP Training</td>
<td>95%</td>
<td>172</td>
<td>203</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>174</td>
<td>207</td>
<td>84%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>307</td>
<td>372</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>95%</td>
<td>158</td>
<td>192</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>95%</td>
<td>159</td>
<td>209</td>
<td>76%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3-Adult Immediate Life Support</td>
<td>95%</td>
<td>0</td>
<td>16</td>
<td>0%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff failed to meet the target of 95% for all 16 training courses. However, for 15 of the 16 training courses over 75% of eligible staff had completed.

The trust submitted the data above stating the completion rate for the 16 eligible staff for resuscitation level 3 adult immediate life support was 0%. The trust on request advised us that the medical staff had higher advanced life support training but that this was not being recognised by the electronic staffing record. The trust told us they were now reviewing medical staff training records to ensure they accurately reflected if medical staff had the equivalent or greater than resuscitation level 3 training.

### Mandatory training – nursing staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security, Violence &amp; Fraud</td>
<td>95%</td>
<td>461</td>
<td>464</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Sharps-Level 2</td>
<td>95%</td>
<td>457</td>
<td>460</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>445</td>
<td>451</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>95%</td>
<td>422</td>
<td>429</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>95%</td>
<td>444</td>
<td>452</td>
<td>98%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing staff in medicine met the trust target for 11 training courses. However, for 15 out of 16 courses over 75% of eligible staff had completed. There was a concern that a third of nursing staff had not completed resuscitation level 3 adult immediate life support. The trust said they were working to increase the amount of sessions available for this training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

_Staff understood how to protect patients from abuse and the service worked well with other agencies to do so._

When we spoke with staff in wards and departments, they told us about safeguarding concerns they had raised. Staff had training on how to recognise and report abuse and they knew how to apply it. Safeguarding training included female genital mutilation (FGM). A staff member we spoke with told us how they and their colleagues had supported a patient when FGM was recognised.

The trust had safeguarding leads in directorates across the trust; the trust executive lead for safeguarding was the Director of Nursing and Midwifery. There were internal and external meetings in the trust to ensure appropriate escalation of safeguarding issues took place. Staff we spoke with knew who their local lead was.

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of November 2017 for medical/dental and nursing staff in medicine is shown below:

**Safeguarding training completion rates - medical staff**

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>12</td>
<td>12</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>189</td>
<td>209</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>184</td>
<td>207</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>179</td>
<td>204</td>
<td>88%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff failed to meet the completion target of 95% for three of four safeguarding training
courses. However, for the four training modules there was a compliance rate of over 85%.

Safeguarding training completion rates - nursing staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>458</td>
<td>464</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>455</td>
<td>462</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>453</td>
<td>461</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>12</td>
<td>13</td>
<td>92%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff met the target of 95% for three out of four safeguarding training courses. The target not achieved for safeguarding children level 3, with one member of staff with training outstanding.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Although control measures to prevent the spread of infection were in place, there was some inconsistency in practice. For example, hand wipes were not consistently offered to patients before meals. In ward 1 and endoscopy we saw clean items in the sluice which were at risk of accidentally become contaminated.

Clinical staff adhered to the bare below the elbows policy to prevent cross infection. They wore clean uniforms and minimal jewellery. There were adequate hand sanitisers and hand washing sinks in all wards, and visitors were encouraged to use them at the entrance to the wards. Staff washed their hands and used hand gel sanitisers frequently. We saw staff actively wearing personal protective equipment (PPE) such as gloves and aprons when appropriate and discarding them when they had completed the task.

The wards and departments had regular hand hygiene audits undertaken. From November 2016 to November 2017, compliance with hand hygiene across the medical care group was 88%, against a target of 95% compliance. We asked some sisters and charge nurses what action was taken if their ward was below the target of 95% compliance. They explained compliance with audits was displayed for patients, relatives and staff to review. Senior staff discussed gaps in compliance with staff at ward meetings and some wards also produced newsletters for their wards or departments with key messages.

Patients who had or were at risk from infections were appropriately segregated in single rooms, warning signs were used to alert visitors and staff about their infection status. The signs also gave guidance on what type of PPE required. PPE was seen appropriately located at the entrance of the single room so staff and visitors could prepare themselves prior to entering the room.

The domestic staff had daily cleaning schedules for the wards and departments. We saw some on display that ward staff could check and follow. Staff undertook cleaning audits were undertaken for wards and departments. Audit results from March 2017 to February 2018 for areas of cleaning that were nursing responsibility ranged from 98% to 100% or more compliant. For housekeeping compliance ranged from 95% to 99%.

The wards utilised disposable privacy curtains and we saw that they were changed in line with the trust procedures and staff confirmed the curtains were replaced as needed. We observed some curtains were changed within the past three months prior to the inspection and were clearly dated.
When we visited the trust no wards were closed due to infections, for example, norovirus. The number of cases has remained low for the last five years. When we visited wards staff were actively ensuring that any patients that may present an infection risk were placed in a single room.

A decontamination lead was in place to support the effective decontamination of endoscopes. Throughout the endoscopy unit, there was an effective dirty to clean flow of equipment process that all staff followed. In each endoscopy treatment room, there was a laminated six step process on the wall to support staff in ensuring endoscopes were always effectively cleaned. The trust followed Department of Health guidance on decontamination of flexible endoscopes. Access to the endoscopy treatment area was restricted as part of infection control management.

In the medical care group from April 2017 to November 2017, there had been four cases of *Clostridium difficile* acquired at the trust. The trust target from April 2017 to March 2018, was no more than 14. From April to November 2017, there had been 10 cases. The trust data was similar to other trusts. (Source: CQC insight). From October 2016 to September 2017 there had been no cases of MRSA acquired at the hospital.

The patient-led assessment of the care environment (PLACE) in June 2017 was 99%. The national average was 96%. The wards within the medical service also displayed the number of infections they had for the previous month for the public to see. There were notice boards on the outside of the wards and included information about infection and hand hygiene results.

Infection prevention and control training was part of the mandatory training that all staff had to complete. Compliance for nursing staff with the training had improved from 85% to 100% (418 out of 470). Medical staff compliance with the training had improved from 52% to 79% (117 out of 179). However, this did not meet the trust compliance target of 95% of all staff to complete.

We noted that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The sharp bins were clearly labelled and tagged to ensure appropriate disposal and to prevent risk of cross infection. This included disposal of cytotoxic materials which were disposed of safely.

We observed staff consistently followed effective infection control procedures in the treatment investigation unit (TIU). Staff used aseptic techniques when setting up infusion and used sterile dressing packs to ensure infection control risks were minimised. This included hand washing in between patients and cleaning of equipment such as blood pressure cuffs on ward 5 and trays. Patients were supplied with wet wipes on their meal trays and we observed on ward 5, ward 25 and in the treatment investigation unit (TIU); these were available. There was a risk patients were eating meals with dirty hands as we saw they were not consistently offered the opportunity to wash their hands prior to meal times. This was the same as the last inspection in October 2015. We saw that hand wipes were available on wards, but discussion with patients confirmed they were not always offered the opportunity to wash their hand before meals. This posed a potential risk of food becoming contaminated by dirty hands and posing a risk to health and wellbeing of the patient.

Equipment and surfaces we checked on the wards and departments we visited were visibly clean. We found one trolley with surface dust where equipment was stored, which when we showed a member of staff was cleaned. Staff followed their internal process and equipment had tags to identify these as clean and ready for use.

We looked in some linen and store cupboards. There some boxes on the floor in these rooms on some wards, which would make cleaning more difficult. When we spoke with staff about this
concern, they explained that additional shelving had been put in linen cupboards and storerooms. The additional shelving was not sufficient in some wards. We saw that in medical ward 1 sluice (dirty utility) room, ward 25 and in the endoscopy department also stored new, clean items for patients’ personal use, for example toiletries. The function of the sluice meant that clean items might be unintentionally contaminated.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Ward and department had resuscitation equipment stored in tamper evident trolleys, which staff checked daily. In the wards and departments we visited checks had been completed to ensure the emergency equipment were safe and ready for use.

The medical equipment that was on the wards and departments was all in date for servicing and safety check dates. Lifting equipment, such as hoists, were serviced six monthly. Staff we spoke with told us the trust organised the servicing rather than individual wards. The equipment library was just installing a new system to track equipment by barcodes.

Waste segregation and removal was seen to be working effectively, including the safe removal of used sharps in bins, which were filled to a safe level.

The stroke ward had dedicated rooms for patients’ rehabilitation. Rooms included a gym and a kitchen for staff to be able to assess patients’ skills following a stroke to prepare meals. These facilities being in the stroke unit, meant if a patient became unwell, specialist help was quickly accessible. The wards all had nurses who were based in the bays to allow for more focused nursing care and observations of patients. The Treatment Investigation Unit (TIU) was bright and airy and patients were provided with recliners which they used during their treatment which patients commented positively about.

The trust took into consideration people who were living with dementia and had adapted the environment which included signage and colour coded doors to help identify washing and toilet areas.

The endoscopy unit had areas for pre and post procedures which ensured that male and female patients ready for their procedures were provided with separate areas.

The trust had four cardiac catheter laboratories. Staff we spoke with explained the laboratories currently being upgraded to ensure patients’ requiring these facilities could receive cardiac catheter laboratory interventions in a timely way.

Medical staff told us and we saw that since the last inspection in 2015 a blood gas machine had been installed in the acute medical unit (AMU). Staff told us this meant there was more effective use of their time, as staff did not need to go to the accident and emergency department for blood gas tests.

Across the medical care group we saw that clinical rooms had no doors. Staff we spoke with told us that there had been recent risk assessments and it was agreed to keep the medicines and intravenous fluids cupboards secure inside the rooms. Equipment such as needles were also secured securely, except in the AMU. In the AMU all equipment was unsecured, and could have been accessed by unauthorised people. The trust health and safety advisors audited some areas of medicine on the 29 March 2018 following our feedback. They undertook an assessment of this area and told us that this was deemed as low risk of equipment being taken by unauthorised people, as the nurses’ station was constantly manned and under direct vision of staff.
Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient; however this was not always in a timely way.

When we inspected in 2015, staff had recently been introduced to a new system of completing nursing assessments on hand held tablets. The risk assessments related to malnutrition, skin integrity, mobility and falls. The system promoted staff to review and update assessments. At the last inspection, staff on the AMU had found the system cumbersome. Staff we spoke with in the AMU and in other medical wards were positive about the system.

The trust used data from the system for audit and monitoring of compliance with the completion of electronic nursing assessments. Compliance from wards and departments within the medical care group on average from February 2017 to February 2018 ranged from 79% to 84%. The target for compliance was 100%. We spoke with sisters and charge nurses about how they were trying to improve compliance with the completion of electronic nurse assessments within agreed time scales. Actions included the nurse in charge monitoring ward compliance during the shift, and speaking with individual staff if their electronic nurse assessments overdue to see if support needed. In addition, on some wards the teams had designated blocks of time when they would review and check electronic nurse assessments up to date.

Wards used different strategies to minimise risk and ensure patients were kept safe. Some wards grouped their patients so that patients at higher risk who needed closer observation were placed in bays closest to the nurses’ station. Other wards had dedicated nurses in each bay who were responsible for the care and supervision of patients in that area only. The discharge lounge did not accept patients at high risk of falls or under a deprivation of liberty safeguards (DoLS), as they would not be able to give those patients the level of observation they would require.

Staff on ward 26 told us about twice daily safety briefings that took place on the wards seven days a week. The nurse in charge discussed patients who were at risk, for example, of pressure damage and falls.

Staff in the medical care group used an electronic system to monitor patients’ vital signs such as pulse, blood pressure and breathing rates. Nursing staff entered patients’ vital signs or observations into the system using electronic touch pads and the system recommended any escalation actions based upon the patients results. The level of escalation required was based upon the national early warning system (NEWS) which gave staff recommendations for example, to increase recording frequency or contact the doctor. The ward nursing and medical staff could access an overview of the patient’s condition through the desktop computers which were located or electronic tablets.

Staff compliance with patients’ vital signs being completed on time was monitored weekly by the trust, and in the medicine care group wards from December 2016 to November 2017 compliance was 93%. An internal audit was undertaken by the trust’s internal auditors in July and August 2017, and part of the purpose was to establish staff’s awareness of the escalation procedure of patients’ vital signs showed deterioration.

The survey was undertaken in the AMU in the medicine care group. The auditors made six recommendations; however, there were no areas of significant concern. One recommendation was that the trust should ensure policies and procedures appropriately communicated and placed in an easily accessible location. The trust was introducing mandatory training on the identification and management of deterioration in January 2018. The trust also planned to place all relevant
information about the identification and management of patient deterioration in a single site on the
trust intranet.

To ensure patients with the highest acuity are made known to staff on their admission, allowing for
better awareness and control of their condition, a method of prioritisation had been implemented
in AMU. Those patients considered most at risk had their notes placed in a red box and more stable
patients in a white box in the medical staff hub. This ensured staff could clearly identify patients
who were more at risk of deterioration.

The wards were supported with any deteriorating patients by an outreach team; this was a nurse
led team of former critical care nurses who supported the wards across the full week, days and
nights. They could access the electronic monitoring system remotely and assess the patients at
risk to ensure their support was targeted.

The trust was involved in the ‘Think Sepsis’ campaign. Staff understood the signs of sepsis and
the importance of patients with sepsis receiving antibiotics within an hour. Seventy two percent of
patients received antibiotics within one hour of arrival to the trust in 2016/2017. This was well
above the national average of 44%. The trust in January 2018 made sepsis and care of the
deteriorating patient training mandatory for staff.

The trust from 1 April 2016 to 31 March 2017 participated in a national cardiac arrest audit.
Although the hospital undertook percutaneous coronary intervention and was a cardiac centre,
the rate of cardiac arrests at the hospital was low per thousand admissions. The trust was less
than 0.5, with the majority of trusts reporting data from 0.5 to 1. The trust felt this to be a result of
correct decisions by clinicians that were either preventing patients’ having a cardiac arrest or
appropriately using ‘allow a natural death’ forms.

Patient falls were followed up by the use of a post falls checklist which included actions,
recordings and a record of the fall. The patient’s record would have a yellow sticker inserted to flag
a fall had occurred. This meant staff could clearly track any incidences of falls. An information
sheet to inform which medicines may contribute to a fall was available for staff guidance.

Wards and departments were prepared for the risk of sudden deterioration in patients’ condition,
for example, a major haemorrhage box of equipment was available in the endoscopy department.
In the discharge lounge a registered nurse was always on duty, and there was an emergency
button that staff could press to summon immediate help.

The World Health Organisation safety checklist was used in endoscopy and cardiology, who
adapted the checklist to suit procedures undertaken in their respective departments. The audit
department undertook an audit in endoscopy from 30 August 2017 to 15 January 2018 of 50
patient records. All patients had a WHO safer surgery checklist, the sign in stage was almost
always fully completed (range 86% to 100%) but not all sections in the time out (range 50% to
100%) and check out (range 52% to 100%) completed. The endoscopy service did not submit an
action plan with the audit results, to demonstrate how compliance to be improved. The cardiac
catheter laboratory manager and a data manager audited compliance with their WHO safer
surgery checklist monthly in the cardiac catheter laboratories. From September 2017 to March
2018 the first three stages ranged from 88% to 98% compliant, for the sign out 65% to 88% and
for the debrief 53% to 75%. The auditors had identified limitations with the current process, and
were implementing improvements.

The trust collated patient bed moves data as part of quality monitoring data. The trust excluded
bed moves that included first clinical move from an admission/ assessment area and moves for
diagnostics treatment, such as an endoscopy. The trust submitted data to us that showed the
number of patients moved more than three times as shown below. The data received did not state whether all the moves were clinical or some non-clinical.

From December 2016 to November 2017, the trust reported that 60 patients had been moved at least three times during their admission.

(Source: Trust Routine Provider Information Request)

The trust had taken actions to improve quality of around bed moves which included raising awareness of the trust outliers’ policy and improved documentation of discussion with patients/carers and families about any bed moves.

At the trust from December 2016 to November 2017 there were 2458 out of hours bed moves of patients. Eighty-one percent (1980) of the moves were from the AMU or older people’s assessment unit, thus ensuring patient were allocated to the appropriate medical care wards as quickly to receive the most effective care.

Ward 9 was used as the winter pressure ward, and aimed at reducing the number of bed moves for patients’ with complex needs and those ready for discharge.

**Nurse staffing**

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

To take account of the National Institute for Health and Care Excellence (NICE) guidance in relation to nurse workforce levels, the trust had a standard operating procedure (SOP) in place to determine when to raise a nursing red flag. This signified an area of nursing depletion and potential reduction in being able to deliver and maintain a high quality standard of care. From June 2017 to September 2017 there were five red flag shifts, from October 2017 to March 2018 there were none reported. On each occasion, the head of nursing and quality investigated and put appropriate support in place, in line with patients’ care needs. Following investigation of the red flag shift in September 2017, several actions were undertaken including agreement to increase wards night nurse staffing template to improve resilience and patients’ care.

All wards displayed on electronic wall screens at the entrance to the ward, this included their expected and actual numbers of registered and healthcare assistants for that day. This information was split into early, late and night shifts and was also available of the trust website for any interested member of the public to access. We observed that the trust was mostly achieving their planned to actual staffing levels in order to keep patients safe.

Specialty senior nurses organised staff on a shift-by-shift basis to ensure that available staff were shared across the hospital to provide the safest cover for the wards. One to one support was available for patients requiring increased levels of observation and support, for example, people living with dementia at high risk of falls.

The trust told us that six monthly reviews of ward staffing levels took place to ensure that the staff establishment matched the acuity of the patients within the wards.

During December 2017 the trust reported staffing levels for medicine showed that in the day registered nurses shifts were filled between 85% and 96% and at night between 63% and 100%. Most of the wards at night had a 90% or overfill rate at night. The ward at 63% was the older persons’ assessment unit, where the fourth registered nurse not always needed for the needs of patients on the ward. The health care assistant day shifts were filled between 84% and 107% and
the night shifts between 102 % and 126%. This data does not include ward 9, which the trust opened for winter pressures on 1 January 2018 for three months. Where shifts were over 100% filled indicated that the trust was covering extra demand such as increased beds or patients with additional complex needs that needed a higher than normal nursing ratio.

Nurses from different wards within the medicine care group staffed ward 9. The sister told us the ward had a high use of bank staff. The ward sister brought the team together prior to opening for a half day training and ‘getting to know each other session’.

The Royal Bournemouth Hospital has reported staffing numbers below for the period April 2017 to November 2017 for nursing staff in medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post - November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Bournemouth Hospital</td>
<td>512.1</td>
<td>495</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>512.1</strong></td>
<td><strong>495</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a vacancy rate of 12% for nursing staff in medicine at Royal Bournemouth Hospital. Please note, the trust did not provide a target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Senior staff at the trust told us they that a lot of work was underway with the recruitment of staff. The head of nursing for the care group told us they were the lead for the development of a band 4 assistant practitioner workforce and nurse practitioner role in the care group. They told us the trust were currently developing their band 4 assistant practitioner positions in the trust. The trust provided a two-week course to support nurses who had not worked for some time for an acute trust. The trust was also working with Bournemouth University, to support nurses who after a long gap wanted to return to practise.

The trust were looking at opportunities to develop other models of care. The head of nursing for the care group told us the last matron post advertised was open to nurses and allied health professional to apply.

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a turnover rate of 4% for nursing staff in medicine at Royal Bournemouth Hospital. This was worse than the trust target of 1% or less.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Senior staff told us work was taking place to improve the retention of staff. Workforce planning was being carried out, with development plans for each area. Other initiatives include development of band 4 roles and physician associate role. The director of human resources also believed that
the introduction of the apprenticeship levy should help with retention of existing staff and attract new apprentices.

In June 2017 the trust launched a research project that aimed to find about factors that influenced registered nurses to stay in the trust and in nursing, to build these into a co-created retention strategy and to implement interventions designed to increase retention in one directorate. One of the directorates involved in the research was medicine for older people.

Sickness rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a sickness rate of 4% for nursing staff in medicine at Royal Bournemouth Hospital. This is worse than the trust target of 3% or less.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Senior ward and department staff told us the human resources department provided good support with the management of staff sickness. The trust also had policies in place to support the management of staff sickness.

Bank and agency staff usage

Staff we spoke with told there us they regularly worked with bank staff, and there were many employed at the trust. Staff with permanent contracts at the trust told us they enjoyed working with the bank staff. Bank staff received an incentive for filling shifts that trust staff sent out at short notice.

There was a recognition system across the trust where staff received remuneration for working extra shifts.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to October 2017, the trust reported 84,068 shifts in medicine. Of these shifts:

- 15,458 (18%) were filled by bank staff
- 1,294 (1.5%) were filled by agency staff
- 3,913 (5%) were not filled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Consultant cover was available 24 hours a day seven days a week either on site or by telephone depending on the specialty. We spoke with medical staff working on the wards who told us they felt well supported, and enjoyed working in the trust.

Consultants were present on site in the AMU from 9am to 8.30 pm Monday to Friday and 12 midday to 8pm weekdays in the AMU. The trust had three consultants for the stroke unit and a
consultant presence on site between 8am and 6pm. At weekends there were consultants available on site from 9am-5pm which ensured cover for the hyper-acute stroke unit and adherence to the thrombolysis pathway.

Medical handovers started at 8am. We observed ward rounds on the stroke unit and in AMU during the inspection and found these were comprehensive and structured. Staff in the AMU handed over patients who had been admitted during the night shifts. Treatment plan were discussed and the pharmacist and discharge liaison staff were also present, discharge planning formed part of this.

In TIU patients’ admissions were planned such as those undergoing Insulin stress test would be required to stay for 6 hours and received 1:1 care.

The Royal Bournemouth Hospital has reported staffing numbers below for the period April 2017 to November 2017 for medical staff in medicine.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post – November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Bournemouth Hospital</td>
<td>224.3</td>
<td>241</td>
</tr>
<tr>
<td>Total</td>
<td>224.3</td>
<td>241</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a vacancy rate of 5% for medical staff in medicine at Royal Bournemouth Hospital. Please note, the trust did not provide a target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Senior staff told us that recruitment of sufficient consultants was a challenge in line with national recruitment shortages. The risk of reliance on locum consultant cover in older people’s medicine wards and stroke was on the risk register. The senior staff in medicine for older people had a recruitment strategy in place, which included actions such as joint posts with acute medicine to widen skills and share expertise across directorates. Five speciality doctors had recently been recruited to ensure effective patients’ care.

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a turnover rate of 18% for medical staff in medicine at Royal Bournemouth Hospital. This is worse than the trust target of 1% or less.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Senior staff told us work was taking place to improve the retention of staff. Workforce planning was being carried out, with development plans for each area.

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a sickness rate of 1% for medical staff in medicine at Royal Bournemouth Hospital. This is better than the trust target of 3% or less.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust did not provide us with the total number of shifts required to be filled, however from November 2016 to October 2017, the trust reported the following bank and locum usage figures:

- 1,045 shifts filled by bank staff
- 2,095 shifts filled by agency staff
- 658 shifts were not filled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Staffing skill mix**

In October 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same.

**Staffing skill mix for the 172 whole time equivalent staff working in medicine at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultant</strong></td>
<td>40%</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Middle career^</strong></td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Registrar group~</strong></td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Junior</strong>*</td>
<td>22%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (SIR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/10/2017 - 31/10/2017)
Records

Staff kept records of patients care and treatment, these were fully completed but not always stored securely.

The trust used two different record keeping systems. Nursing and current medical records including patients’ prescription records were paper based. Ward based patient safety risk assessments were electronically recorded in a standalone electronic system; nursing staff entered information on the patient’s admission using a tablet. Assessments showed as red, amber or green, depending on when they were due.

We reviewed 26 medical and nursing records. We found that records were detailed and contained risk assessments and treatment plans. In AMU, TIU, ward 1, ward 26 and ward 5 for example we saw clear records of care provided. In ward 5 we observed staff maintained accurate records of food and fluid charts. In TIU patients' vital signs were monitored and recorded and all records in ward 5 and the TIU were maintained safely and securely. In the stroke unit patients records were kept in locked trolleys; however medical staff did not always lock these when they were undertaking their ward rounds. Staff were aware and on several occasions we saw senior staff locking notes trolleys.

The paper records should have been stored in the notes trolleys. When we visited wards 24,11, stroke and ward 9 we found medical records that had not been stored securely in the notes trolleys. The notes trolleys were accessible using a key pad, to prevent unauthorised access. However, on all the wards we visited the trolley could be opened without keying a number in.

When we attended for an unannounced inspection on 27 March 2018, a screen saver had been placed on computers that reminded staff to ensure patient records were stored securely. A meeting with the ward clerks was also planned for 28 March, to highlight their role in ensuring patient notes were stored securely.

Paper records that were not stored in the notes trolleys were charts used for monitoring fluid intake, bowel movements and dependency of patients. They were either on trolleys within bays, or on the end of patients’ beds. Staff storing these charts in a defined patient area, minimised the risk of non-authorised people reviewing these records.

All wards used a nursing handover sheet to refer to, most contained more details and updates of patient’s care than was recorded in the formal record. Staff we spoke with told us that the sheets were updated regularly throughout the shifts and were shredded to protect patients’ confidentiality at the end of shifts. There was no historical record therefore of the handover sheets.

Medical records of patients demonstrated medical consultants and junior doctors reviewed them regularly. This included medical patients being treated on wards, other than the specialty medical ward indicated for their condition. We also observed that medical staff bleep numbers were after signed entries, so staff on wards could contact the appropriate member of medical staff if needed.

Medicines

The service mostly followed best practice when prescribing, giving, recording and storing medicines. However, on three wards we found intravenous fluids that were out of date. We also found concerns with the storage of medicines and staff competency in the discharge lounge.
The trust stored medicines and intravenous fluids securely in locked wheeled trolleys, and secure cupboards. We observed that wheeled drug trolleys when not in use were all secured to a designated wall space. Patients’ own medicines were stored in patients’ rooms or bays within locked patient own drug ‘pod’ lockers. Controlled drugs (CDs) were stored in appropriate locked small cupboards with the keys held by the nurse in charge of the ward. The night staff checked CDs daily and we saw this was recorded. A random check of the CDs confirmed the accuracy of the checks. The current CD administration record books were seen locked within cupboards.

The medicine storage refrigerator temperatures were checked and recorded daily, ensuring temperatures did not go above or below recommended storage temperatures which would impact on the medicines’ effectiveness.

In the endoscopy department medicines were available if required, to reverse the effect of medicines given to help patients relax during procedures.

We observed good pharmacy support to the wards. On some of the wards and departments we visited pharmacy staff had dedicated areas to work. This involved pharmacists checking charts and the identification of any potential issues, to ensure patients received appropriate medicines. Pharmacy staff left messages in green for medical and nursing staff to respond to. Pharmacy staff were also able to dispense patients’ medicines to take home from the wards. Pharmacists had a presence on most wards seven days a week, and there was also a notice with their bleep number on if not present on the ward.

We looked at 26 prescription charts for completeness and to ensure that missed doses were appropriately coded, overall they were completed well. We saw that patient allergies were noted and the type of reaction described. One patient chart we looked at, did not have a signature to show if a medicine had been administered. When we spoke with the nurse in charge, this was immediately followed up.

Medicine’s data from an internal audit relating to 3881 patients in the medical wards prescription charts surveyed from April 2017 to March 2018 showed that 89% of patients’ medication charts had been reconciled within 24 hours. The aim of medicines reconciliation on admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. The information also showed that 99.3% patients had their allergy status completed and of them 91.5% had a red ‘alert’ arm band applied. Of the omitted doses, 32.3% had a valid clinical reason documented 4% either had a question mark or were left blank, 51 % were refused by the patient and 15.8% medicines were not available. There were arrangements in place for monitoring missed dosages where the pharmacist and pharmacy assistant reviewed the medicines charts for omission such as antibiotics.

We observed patients’ being administered with their medicines on several wards; staff appropriately checked their identity bands, asked for identification against the chart details to ensure the patient was correctly identified. However, on ward 9, a nurse had signed the chart as medicine being given to the patient at 12midday, but had not ensured the patient took their medicine before moving to the next patient. We observed a second nurse coming along to see the patient at 2pm, removing the medicine which was Paracetamol. The patient said to the nurse, ‘I have such a pain in my foot’. The nurse then reviewed the patient’s medicine chart, to check medicines that could be given at 2pm to relieve the patient’s pain.

When we visited the discharge lounge at our short notice inspection we found that patient own medicines were not securely managed. Medicines received from pharmacy were checked then given to patients. There was risk of patients picking up the incorrect bag of medicines. When we went back for our unannounced inspection 27 March 2018, the trust had taken prompt action to
mitigate the risks we had raised. A temporary secure box had been obtained in which all patients’ medicines were placed. Following the inspection the trust provided evidence they had taken further action and had put in place a locking facility with 15 compartments, that would enable individual patients’ medicines to be stored separately. The registered nurse in charge told us there was no standard operating procedure currently if a patient had controlled drugs, the trust was in the process of developing this.

The discharge lounge healthcare assistants (HCA) involved in checking patient discharge medicines had undertaken training, and on completion were awarded with a certificate of completion. For the healthcare assistant who had undertaken the training working in the discharge lounge at the time of our inspection, their workbook was dated 24.07.15. There was no ongoing refresher training on competency document to support the training package. At our unannounced inspection we noticed a patient that was given medicines hung on the back of the chair they were sitting on, there were no checks. The healthcare assistant did not follow the checks. This was immediately raised with the nurse in charge, who said a second healthcare assistant in the discharge checked the medicines were correct on the way to the ambulance.

Staff in the discharge lounge told us it was a regular occurrence to wait for patients’ medicines, and this could take up to six hours. Staff told us that sometimes discharges failed due to delays with medicines for patients to take out. Staff working in the discharge lounge did not always raise this issue as an incident, which may not have helped the trust recognise this risk.

We found two intravenous fluids that with expiry dates of October 2017 and February 2018 on ward 24 (short stay older people’s ward), thirteen on ward 11 (haematology) and two on the stroke unit dated February 2018. The intravenous fluids include sodium chloride with potassium that expired in October 2017 and glucose with potassium chloride that expired in February 2018. When we spoke with the nurses in charge of these areas the intravenous fluids were removed from the wards. The trust had assured us that they had a robust process for checking intravenous fluids that included two staff members which eliminated the risk of using out of date fluids. Following the inspection, the trust had completed an audit of intravenous fluids and staff had been reminded to tighten stock control procedures. Following the short notice unannounced inspection the trust took the following actions:

- Algorithm of stock rotation process shared with all ward areas and displayed in fluid storage areas
- Standard operating procedures (SOP) for ward medicines top up (including intravenous fluids) updated.
- Pharmacy SOP for ward top up, that included expiry dates updated.
- Safe and effective medicines management action plan developed. The trust set up a task and finish group to review and streamline medicines policies within the trust and review appropriate levels of training.

In the AMU the intravenous fluids were stored in an area behind the nurses’ station. An initial risk assessment was completed in October 2015. The trust then undertook a further assessment of this area and continued to deem the area as low risk of equipment being taken by unauthorised people, as the nurses’ station was constantly manned and under direct vision of staff.

**Incidents**
Overall, staff managed patient safety incidents well. Staff were able to identify incidents and gave us examples of things they would report as incidents such as patient falls, medicines errors and pressure ulcers. They discussed situations which should also trigger incident investigation including near misses. Staff we spoke with were fully aware of their responsibilities and knew how to report an incident on the hospitals electronic reporting system. Staff told us there was a positive incident of incident reporting and they were encouraged to do so.

The medical care group reported 5395 incidents from November 2016 to November 2017, 2990 (55.4%) incidents were no harm. 147 (2.7%) incidents resulted in moderate or severe harm and 10 (0.2%) were serious incidents. Patient falls were the most reported incident within the same period, which were 25% of all incidents.

The ward managers we spoke with had a good understanding of incidents in their respective areas. Department managers also completed an incident form if a patient visited a department from the medical service for a test, and there was an adverse event. For example, if a patient visited X-Ray and there was an incident involving ionising radiation (medical exposure) regulations 2000 (IR(ME)R). The department manager completed an incident form in line with IR (ME)R. Each ward and department shared learning and improvement actions from incidents in various ways to make sure all staff received feedback. These included team meetings, newsletters, handovers and safety huddles. For example, staff told us at the twice daily safety huddles patients at risk of falls were always discussed. The trust had also ensured prompts easily accessible for staff to help prevent patient falls. For example, all the wards we visited had a laminate sheet with a list of medicines to be avoided for patients at risk of falling, either attached to the medical notes or medicines trolley.

Staff reported incidents through the learning event reporting (LERN) on line system. The hospital carried out their investigation based on the National Patient Safety Agency (NPSA) Root Cause Analysis Tool Kit principals. The trust had developed their own RCA investigated kit to support staff. The report included evidence of discussion with the patient’s family members throughout the patient’s treatment. The investigation team had identified learning points and set out an action plan to mitigate the risk of this type of incident happening again. Serious incidents are discussed at the Trust Quality and Risk Committee, and at Directorate Risk and Governance meetings.

The care group undertook mortality and morbidity reviews two to three monthly within the directorates. When we reviewed the minutes of these meetings there was evidence of learning, and actions to be taken forward. In older people’s medicine, issues around mortality were discussed bimonthly as part of the junior doctors’ educational meeting where minutes were not taken. As a result of discussions in older people’s medicine changes included improvements in handover processes, timely access to radiological investigations and processes for repatriation of patients. In the future older people’s medicine were planning to record discussions at mortality meetings on a template that had just been produced by the trust mortality surveillance group.

**Never Events**

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

From January 2017 to December 2017, the trust reported three incidents classified as never events for medicine.
A never event had occurred in August 2017 that related to the misplacement of a nasogastric feeding tube in the stroke unit. The trust nasogastric tube policy was updated to reflect learning from the investigation. This detailed additional actions that were above and beyond the requirements of a NHS patient safety alert issued in relation to nasogastric tube placement in July 2016 for trust actions by April 2017. The serious incident investigation confirmed (as agreed with NHS England and NHS Improvement) that the trust was fully compliant with the alert. This was also agreed at inquest.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Pressure ulcer meeting SI criteria with three (30% of total incidents).
- Slips/trips/falls meeting SI criteria with three (30% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (10% of total incidents).
- Treatment delay meeting SI criteria with one (10% of total incidents).
- All other categories with one (10% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (10% of total incidents).

(Source: Strategic Executive Information System (STEIS))

The duty of candour is a regulatory duty that relates to openness and transparency. It requires the providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust made...
staff aware during induction of the resources available to support the statutory application of duty of candour. This included a policy and a prompt when staff completed an incident form and a prompt as to whether duty of candour should be considered. Staff we spoke with had a good understanding of duty of candour, and senior staff were fully aware of their initial and continuing responsibilities.

Safety thermometer

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

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

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

Data from the Patient Safety Thermometer showed that the trust reported 79 new pressure ulcers, 17 falls with harm and nine new catheter urinary tract infections from December 2016 to December 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

The prevalence rate for pressure ulcers regularly fluctuates between around one and four throughout the entire reporting period.

From April to June 2017 and also in October 2017, there were no falls reported within medicine within the previous 72 hours when the Safety Thermometer was undertaken at the trust.
The trust reports a total of nine catheter induced urinary tract infections, however from February to June 2017, there were none.

(Source: Safety thermometer - Safety Thermometer)

Information relating to the safety thermometer data was displayed in the entrance areas to individual wards for the information of both staff and patients and visiting relatives. Senior staff were aware of the ward’s performance and looked at reduction of falls and hospital acquired pressure ulcers.

Is the service effective?

Evidence-based care and treatment

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

The medical care group had pathways and protocols for a range of conditions, which took account of national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. For example, for heart failure, stroke, diabetes, respiratory conditions, falls and pressure ulcer prevention, memory care pathway and sepsis.

To support staff in delivering evidence based care, we observed pathways of care that had been mapped out displayed on large laminated posters. In the stroke unit, the process for undertaking a continence assessment and managing thrombolysis pathways were detailed yet clear to understand. Staff could also access policies and procedures on the hospital intranet to support the delivery of effective care to patients.

The endoscopy department was awarded Joint Advisory Group (JAG) accreditation in gastrointestinal endoscopy in January 2018. JAG is a quality improvement and service accreditation programme for gastrointestinal endoscopy. They assess endoscopy units to monitor whether they meet and maintain the JAG quality standards. This meant the endoscopy unit met the national guidance for delivering an endoscopy service, which included routine auditing of the service provided.

In line with national guidelines, patient records on the Acute Medical Unit (AMU) showed they were seen and reviewed by a consultant twice daily. Once transferred to general ward, records we reviewed showed, in line with national guidelines, most patients were reviewed during a consultant led ward round once every 24 hours. However an audit undertaken by the trust in 2017 showed that from Monday to Thursday there was over 90% compliance, but this fell to 67% and 63% over the weekend. The Trust felt this to be a recording issue, and planned to focus on achieving documentation of daily reviews. The trust were specifically focusing on how white board rounds were recorded and the decisions and actions that arise from these particularly at the weekends.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences. However, average staff compliance with the screening tool from February 2017 to February 2018 in the medical care group was 84%.

Staff assessed patients’ nutritional status using a validated screening tool, the malnutrition universal screening tool (MUST), within 24 hours of admission. This tool allowed staff to identify
risks and actions to minimise the risk of malnutrition in patients by ensuring they received adequate nutrition and fluids. Staff also provided patients with supplements such as fortified drinks. The trust expectation was that patients’ nutritional assessments were reassessed weekly. However, average compliance with the screening tool from February 2017 to February 2018 in the medical care group was 84%. Senior staff on the wards were taking action to improve compliance, that included highlighting to staff gaps in compliance and seeking support from ward nutrition link nurses. Staff were able to refer patients to a dietitian if indicated by the assessment, and wards had link nurses to support the staff with nutrition issues or queries.

Patients who had difficulties eating and drinking were referred to speech and language therapy (SALT) or occupational therapy for relevant assistance. When we visited ward 5 we saw detailed care plans and some charts prepared by SALT with types of foods patients could manage, position patient should be in before being supported to eat and drink and signs to look out for indicating that the patients’ condition may have changed. At that point feeding should be stopped, and the patient re-assessed. The 26 records showed that nutritional risk assessments were completed and staff monitored patients’ food and fluids intake.

The trust had a feeding at risk decision and guideline form they had developed. The form was for use with patients who were at risk of food/ fluids entering their lungs as a result of their poor swallow, where a patient was not appropriate for feeding through a tube into the stomach. The form was sent with patients on their discharge to their own homes, rest homes and nursing homes.

The medical wards had protected meal times where doctors ward rounds would stop, so patients were not disturbed whilst eating. We saw staff assisting patients at meal times if additional help was required. This included appropriately trained volunteers (including non- clinical staff) supported meal times and assisted patients. There were signs invited relatives/ visitors to speak with staff, if they wanted to visit at mealtimes, to support their loved one at a mealtime.

We observed a ‘lunch club session’ on the stroke unit. Staff offered people choices such as ‘would you like more gravy?’ Staff also made the club a social session with general chat, offering practical support where needed. These ensured mealtimes were a sociable and pleasant experience for patients ultimately aimed at improving the patients’ nutritional intake as well as having other benefits.

On the older people’s medicine wards and stroke ward the dieticians and staff run food focus groups to help support improved nutrition for patients with poor appetite.

Patients we spoke with were complimentary about the food, saying there was a good variety and it was healthy. However, two patients on an older persons ward thought the food was bland. The patient –led assessment of the care environment (PLACE) in June 2017 rated the food at 84%, it was rated as 86% in 2016. The national average was 90%. There was positive feedback from patients’ about the availability and quality of food from our survey.

**Pain relief**

Staff assessed and monitored patients regularly to see it they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used a numerical score to measure pain experienced by patients. If a patient was unable to communicate verbally, for example a stroke patient or someone with advanced dementia, medical, therapy and nursing staff took into account the patient’s body language to determine the level of pain they were experiencing. For people with dementia a nationally recognised tool, the Abbey
Pain Scale, was in use. The Abbey Pain Scale is designed for the measurement of pain in people with dementia who cannot verbalise.

Patients we had conversations with told us their pain was well controlled, they received pain-relieving medicine when they requested it.

The trust employed an acute pain team that staff could contact for advice if needed.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. Patient outcomes were mostly positive. Staff had action plans in place where needed, to improve patient outcomes.

The medical care group participated in many national audits, for example, the Sentinel Stroke National Audit Programme (SSNAP). National Diabetes Inpatient Audit. (NADIA) and lung cancer audit. National surveys the trust had participated in included the national cancer patient experience survey. Staff also undertook local clinical audits, during 2017 there were 10 audits that had been completed and actions generated where needed to meet evidence based practice.

The trust monitored patients’ outcomes through national clinical audits, use of national mortality benchmarking tools, national patient surveys and through internal audits and surveys. We saw examples of action plans that had put in place in the prevention of falls and in stroke, to support improvements

**Relative risk of readmission**

**Trust level**

From September 2016 to August 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in Cardiology had a higher than expected risk of readmission for elective admissions
- Patients in medical oncology and general medicine had a lower than expected risk of readmission for elective admissions.
- Patients in general medicine, geriatric medicine and cardiology had a lower than expected risk of readmission for non-elective admissions

**Elective Admissions – Trust Level**

![Elective Admissions Chart](chart.png)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

**Non-Elective Admissions – Trust Level**
From September 2016 to August 2017, patients at Royal Bournemouth Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in medical oncology and general medicine had a lower than expected risk of readmission for elective admissions.
- Patients in Cardiology had a higher than expected risk of readmission for elective admissions.
- Patients in general medicine, geriatric medicine and cardiology had a lower than expected risk of readmission for non-elective admissions.

**Sentinel Stroke National Audit Programme (SSNAP)**

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit from April 2017 to July 2017.
The following table shows the results by team. Occupational therapy, speech and language therapy and MDT working were the best performing teams scoring an A in both quarters. The stroke unit was the worst performing team scoring a C in both quarters.

We spoke with the service leads as to how they were planning to improve and sustain the ratings one to three in relation to the stroke unit. The stroke service had an action plan in place with timescales; actions included close working with radiology and partners such as the ambulance trusts.

### Royal Bournemouth Hospital

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Dec - Mar 17</th>
<th>Apr-Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>2) Stroke unit</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>8) MDT working</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>9) Standards by discharge</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>10) Discharge processes</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

Team-centred SSNAP level (after adjustments)

Team-centred Total KI level

Overall scores

<table>
<thead>
<tr>
<th></th>
<th>Dec -Mar 17</th>
<th>Apr-Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

**Source:** *Royal College of Physicians London, SSNAP audit*

**Heart Failure Audit**
In-hospital Care Scores

Results for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in the 2015 Heart Failure Audit were similar to the England and Wales average for all four of the standards relating to in-hospital care.

Discharge Scores

Results for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust results were similar to the England and Wales average for five of the seven standards relating to discharge.

Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit found 82% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which is worse than the England average of 83.7%. It is also worse than the trust’s 2015 score of 83.3%.

(Source: NHS Digital)

The diabetic team were taking action to improve diabetic care for inpatients. The audit highlighted that minimal foot checks were happening through the trust. The service had reviewed policies which included changes to documentation to support compliance. Foot checks on paper had been successful to a certain extent; however, the service was working with IT to have foot checks added to the electronic nurse assessments, so compliance could be better monitored. The podiatry service was also failing to see patients within 24 hours of referral. Actions were being taken to improve the time patients seen within which included using electronic referrals and increasing consultant and podiatrist time in the diabetic clinic.

Actions had also been taken to ensure staff awareness of diabetes. Alongside all clinical areas and wards having a diabetes link nurse, resource nurse meetings, insulin on wards had been streamlined. The trust now only has four stock insulins on wards’, kept at room temperature with back up insulin in the fridges. This change was launched alongside the self-management policy and paperwork for the trust improving safety for patients who want to administer their own insulin.

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

<table>
<thead>
<tr>
<th>2014/15</th>
<th>nSTEMI patients seen by a cardiologist or a</th>
<th>nSTEMI patients admitted to cardiac unit or</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>nSTEMI patients that were referred for or had angiography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>member of team</td>
<td>ward</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------</td>
<td>------</td>
</tr>
<tr>
<td>Royal Bournemouth Hospital (number of cases)</td>
<td>488</td>
<td>488</td>
</tr>
<tr>
<td>Royal Bournemouth Hospital (%)</td>
<td>99.4%</td>
<td>82.4%</td>
</tr>
<tr>
<td>England: overall (number of cases)</td>
<td>47309</td>
<td>47309</td>
</tr>
<tr>
<td>England: overall (%)</td>
<td>96.2%</td>
<td>55.8%</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 87.6%, which was worse than the audit minimum standard of 90%. The 2015 figure was 82.0%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 23.9%. This is not significantly different to the national level. The 2015 figure was 22.0%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 58.2%, this is not significantly different to the national level. The 2015 figure was 47.0%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 84.6%, this is not significantly different to the national level. The 2015 figure was 88.0%.

The one year relative survival rate for the trust in 2016 is 32.0%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

The trust has a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 43% this was worse than the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 36% this is worse than the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 36% this is worse than the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 75%, this is worse than the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust had put an action plan with timescales in place following the falls audit 2017 results. This had five reference points that included an action to ensure clinicians request lying and standing blood pressures and are acted on by nursing staff following recognition of a positive result. Steps in place to support improvement included ward leads to ensure all staff are 100% compliant with their falls electronic learning. Also spot check surveys to be undertaken regarding the recording of lying and standing blood pressures and actions taken to ensure compliance.
Competent staff

The service made sure staff were competent for their roles. Managers regularly appraised staff, and held regular meetings to support them.

Appraisal rates

From December 2016 to November 2017, 91% of staff within medicine at the trust had received an appraisal, which was higher that the trust target of 90%

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>95</td>
<td>100</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>113</td>
<td>121</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>297</td>
<td>321</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>55</td>
<td>60</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>413</td>
<td>454</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>93</td>
<td>105</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>95</td>
<td>111</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Qualified allied health professionals, for example physiotherapists, and medical staff were within 5% of the target of 90%. We reviewed two staff appraisals which were well structured and thoroughly completed.
There was a trust wide induction, which was mandatory for all new staff. A healthcare support worker we spoke with who had started with the trust approximately four weeks ago said how helpful the induction had been for them. The trust required temporary staff to complete a trust induction pack on first working at the trust. Temporary staff we spoke with confirmed they had been given an induction to the ward on their first shift.

Staff we spoke with in specialised areas told us about additional training undertaken to ensure their competence. This included staff in the cardiac day unit learning how to recover patients from a general anaesthetic safely, staff working in the stroke unit how to complete the National Institute of Health Stroke Scale (NIHSS) and ‘breaking bad news’. Staff in the stroke unit, told us about weekly ‘Thoughtful Thursday’ sessions. The session planned for the week of our inspection was about infection prevention. A senior nurse in AMU told us that two to three staff undertaking a course called ‘Managing Mental Health in a Non-Mental Health Setting’.

To support staff maintain their competence the trust ran personal resilience training to ensure they were better equipped to provide person centred care and support patients. This training ran as a focus group. The spiritual care volunteers team also ran regular mindfulness sessions for staff focusing on compassionate care and kindness.

The trust has invested and implemented in a bespoke security support worker role, whereby individuals are trained in the care of patients who are restless and agitated. The training package for the role was run in house.

Nurse endoscopists who were fully trained to undertake diagnostic endoscopy procedures and also worked independently. Band 5 nurses all trained in consenting patients for endoscopy.

During our inspection we spoke with practice educators who provided educational learning and teaching to staff. They told us how they provided teaching, for example, on staff induction and also working alongside staff working in the wards. A practice educator from respiratory told us they trained staff in the management of patients with asthma.

Staff told us how they had access to clinical nurse specialists (CNS), ‘champions’, link nurses and the specialist outreach teams who provided advice and support for patients and staff in different areas. Staff told us they found these specialists helpful and they were easy to get hold of. During our inspection we saw specialist staff assisting general nurses in a supportive and inclusive way.

The junior doctors we spoke with told us they felt supported by consultants and senior staff. They told us they could access consultants for help and advice where necessary. There was protected time for their development and junior doctors told us this was adhered to. On all the medical wards and departments we inspected, we saw consultants supporting and educating their junior doctors whilst carrying out their duties.

We observed and spoke with volunteers in the medical wards and departments. They told us of the induction programme, including a disclosure barring service (DBS) check and the mandatory training received before they could assist patients in the wards and departments. They were managed by the voluntary services team but each volunteer was supervised by staff on a day to day basis by staff in the wards and departments they worked on. Volunteers we observed in the wards and departments were valued and trusted members of the team, embedded in the workings of the wards and departments. The volunteers treated patients in a caring and respectful way.

We spoke with a student nurse on ward 1 who was pleased to be part of a Collaborative Learning in Practice Programme (CLiP). This was a coaching model, where students were encouraged to take the lead in their practice, caring for their own patient group and supporting the learning
through identified daily learning outcomes. The student themselves are coached by registered staff with additional mentor support. On ward 1, a four bedded bay was segregated for the CLiP model. The patients, registered nurse supervising and student nurse were all very positive about the model for developing confident and competent nurses.

**Multidisciplinary working**

*Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.*

We were told of regular multi-disciplinary team (MDT) meetings that took place within the medical specialities. This included within the older persons wards, cardiology, stroke unit, oncology and endoscopy. On the day of our inspection on the stroke unit, we were told of an MDT to take place later that morning to establish plans for patients with complex needs.

White board rounds were held on wards daily, to ensure plans to meet patients' needs were clear, and any delays in their care pathway were managed. We attended a white board round led by a senior nurse, where thorough plans to ensure patients' needs met effectively were provided by the occupational therapist, physiotherapist and speech and language therapist.

Staff told us there was a dedicated MDT to support patients who were outliers. Staff on the wards told us this worked well for patients. Staff also told us of the respect there was between the different disciplines.

The medical care group also worked closely with the community MDT, to support the early discharge of patients.

We spoke with pharmacists who were allocated to the wards. They explained they had a dedicated space on wards with a shorter length of stay, that included short stay older persons wards, stroke unit and some of the medical wards. When we spoke with staff they told us having the same person allocated, helped establish good working relationships and supported continuity of care.

Staff told us how much patients benefited from the support from the specialist nurses, in meeting patients' needs. Specialist nurses included the arrhythmia nurse, alcohol nurse specialist and palliative care team.

**Seven-day services**

*The trust provided medical care services across seven days a week, there were consultants either on call or on site over the 24-hour period.*

The trust reported on their progress towards the ten standards to provide seven-day services as per NHS England (2015) ambition to end the variation in outcomes for patients admitted to hospital in an emergency at the weekends.

The hospital at night team provided senior clinical leadership cover of the hospital out of hours. The team consisted of junior medical staff and senior nurses. The critical care outreach team was also available seven days a week 24 hours a day to access and provide support for deteriorating patients on the medical wards.

Physiotherapy services and occupational therapists were provided seven days a week. Pharmacy services were available seven days a week with a slightly reduced service at the weekend. There was an on call service for when the pharmacy closed.
Health promotion

People who use services were empowered and supported to manage their own health, care and wellbeing to maximise their independence. They felt they were involved and supported in the decision making process of their treatment.

We saw arrange of health promoting leaflets and posters displayed in the medical wards and departments. These included information on alcohol awareness, how to stop smoking and reducing the risk of a further stroke. On ward one there was poster that included pictures of the damage that alcohol can do the liver, with measures patients could put in place to improve the health of the liver.

Staff on ward one were also working with the local authority to gain practical support for patients on discharge that were homeless.

We saw that leaflets and booklets were available and given to patients after treatment and discharge to help them adjust to life following ill health. For example, on the cardiac care wards we saw information leaflets about certain medical conditions, this included recovery and life after cardiac problems. Staff gave cardiac rehabilitation patients a detailed information booklet which included physical and emotional recovery guidelines. Staff told us the aim of the information was to support patients in adjusting their life style to prevent readmission.

The respiratory service provided pulmonary rehabilitation for patients with chronic lung diseases. Staff through education and exercise aimed to help patients understand and manage their symptoms and everyday problems in order to improve their quality of life and hope to reduce their hospital admissions.

The trust supported the end pyjama paralysis campaign where patients were encouraged to get dressed and out of bed. The campaign was aimed to help patients avoid the feeling of them being bed bound or chair bound whilst in hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated some variation in how and when to assess whether a patient had the capacity to make decisions about their care. Staff followed trust policy and procedure when a patient could not give consent.

Most staff we spoke with understood the Mental Capacity Act 2005 (MCA) and its relevance to their role. The trust had a policy in place, and staff we spoke with told us they had completed Mental Capacity Act training and Deprivation of Liberty Safeguards training (DoLS) on line. Qualified staff had undertaken additional enhanced mental capacity act training.

The trust had a clear process for DoLS applications that were submitted on line. We looked at two applications on ward 1, and one each on wards 4 and 5. Staff had completed the applications clearly and thoroughly. We reviewed a DoLS application on ward 9. Completion of this application by staff was delayed as the patient had received personal care under best interests on the 8 and 9 March 2018 but the DoLS application was not completed until 13 March 2018.

Wards 24 and 25 were both short stay older persons’ wards. Both wards had a clear process in place for DoLS applications but they varied in approach. Staff on ward 24 completed for every patient who lacked capacity, and on ward 25 only for when staff were actively restricting the patient’s liberty, for example administering medicines covertly. The variation in approach may cause confusion for staff and the receiving local authority that may mean inconsistent outcomes for the patient.
We asked staff what training they have to physically restrain a patient who maybe agitated or actively trying to leave the ward. Staff told us they had received conflict resolution training and that they would hold the patient’s hand. We asked staff on ward 24, short stay care of older people, how they manage if a patient was punching, kicking or hitting out. Staff said they would call security to assist. The trust started providing ‘breakaway training’ for all staff working on the older people’s medicine wards and the AMU in March 2018. We checked two patient care plans who had been punching, kicking and hitting during personal care. There were no specific care plans in place to support staff with meeting these patients’ needs, to support staff in providing effective care and managing these behaviours in a consistent manner. On ward 9 we observed staff supporting patients who were confused using distraction.

From November 2016 to December 2017 staff on the medical wards made 391 DoLS applications of which 31 were approved. From the monthly data provided by the trust a large proportion of patients had regained capacity or were well enough to be discharged before their DoLS applications had been assessed by the local authority. Staff we spoke with said the local authority could not meet the demand to come and assess applications, which is similar to the national picture.

We reviewed four ‘allow a natural death’ forms. Medical staff had completed these forms thoroughly, and the decision for the four patients’ was endorsed by a consultant.

We observed staff seeking consent from patients before undertaking personal care with patients. This included before taking patients’ blood pressure and placing the blood pressure cuff on their arm and changing a patient’s medicine patch.

Staff obtained written consent from patients where a proposed procedure carried significant risks. This written consent process involved two stages, the first being the provision of information, the discussion of options and initial (verbal) decision, and the second being confirmation that the patient still wanted to go ahead. We saw the information given to patients prior to a gastroscopy procedure, which clearly explained the benefits and risks. On the cardiac ward we observed that patients were not always given a copy of their consent form. Patients signed consent forms as confirmation they wanted to go ahead with a procedure on the day of the procedure. However, on reviewing the trust’s consent process, patients had information relating to benefits and risks of procedures in the written and verbal information provided in the pre-assessment process. There was a separate consent form for those patients without capacity to sign. The patients’ capacity was assessed prior to the alternative form being used in the patients’ best interests.

### Is the service caring?

#### Compassionate care

*Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with respect. Staff introduced themselves to the patients before starting any care interventions.*

We undertook a short observational framework for inspection, known as a SOFI. This is a tool developed with the University of Bradford’s School of Dementia Studies and used to capture the experiences of people who use services who may not be able to express this for themselves. We undertook the observation on two older people’s wards. We observed good communication and positive interactions with patients from all members of staff. The communication was all at a relaxed pace, and in a way that recognised care and concern.

Patients told us and we observed the positive care they had received whilst an inpatient on the ward or in a department such as endoscopy:
• By a patient in the acute medical unit (AMU) ‘First class. Never seen so many focussed people’.
• By a patient in the stroke unit ‘Everyone is very helpful’.
• A patient on ward 5, older persons ward for people with complex discharge planning needs ‘They are all angels – they do a fantastic job’.
• A patient in the coronary care unit ‘Care is excellent. Not a bad word to say about any of the staff’
• A patient on ward 26, older persons assessment unit, ‘fantastic – lots of tests’
• A relative of a patient having an endoscopy ‘My husband has dementia but they have looked after him extremely well. We had another appointment in the hospital and someone made this appointment for the same day’.
• A matron responded immediately when a patient wandered out of a bay who had lost her way.
• If patients’ were concerned about being able to sleep, staff offered them earplugs and an eye mask.
• Staff recruited volunteers to ensure patients’ in the discharge lounge felt supported and cared for, by volunteers sitting with them for a chat, or bringing a drink whilst they were waiting for transport home.

Patients told us of ways they had been treated with dignity and respect. For example:
• By a patient in endoscopy ‘I’m so impressed with the gowns, much better than the ones before that left you exposed at the back. Now they wrap round you well’.
• Doctors on the stroke unit ‘knock, knock – are we okay to come in? There’s quite a few of us’.
• A patient in the AMU ‘the doctors come and pull the curtains and talk to me about what is going on.’
• A patient in the treatment investigation unit ‘staff very caring and respected my dignity and other patients at all times’.

Patients we observed and spoke with had their call bells to hand to enable them to ring for help if needed. Patients we spoke this us did not express any concerns about the time that staff it took to respond to call bells. However, we did have one enquiry to our website that did express concerns with the timeliness of call bells answered during the inspection period. The trust undertook a monthly audit across the care groups called care campaign, to identify if there were any aspects of care they should focus on to improve patient experience. Audit results showed a care group average of 86% around call bells being answered in a timely manner. The trust then did a trust wide audit to determine how accurate this was: 60% answered within 2 minutes and 93% answered within 4 minutes. The trust has now added actions including answering call bells into everyone’s business to general and doctor inductions. The trust also told us that further quality Improvement work was in progress with matron leads.

We observed an interaction on ward 5 where a patient was supported to take their medicines and was provided with a cake. Similarly, we saw staff kneeling by the bed to ensure they were not standing over a patient who was confused and supported them with care and compassion to eat
their meal. We also saw patients living with dementia receiving constant reassurance in a calm and supportive manner.

However, we observed one example when care was not so positive. On ward 9, winter pressures ward, staff did not close a patient’s curtains when about to start emptying the urine from their catheter bag into a bottle. The member of staff did not protect the patient’s dignity as you could see the patient with their legs exposed in the room. The staff member then closed the curtains before emptying the patient’s catheter bag.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the Royal Bournemouth Hospital was 34% which was better than the England average of 25% from December 2016 to November 2017.

In November 2017, the average response rate across the medicine wards was 97%.

*(Source: NHS England Friends and Family Test)*

From December 2016 to November 2017 people recommending the trust ranged from 97% to 99%. When we inspected and looked at February 2018 and March 2018 friends and family data on some of the wards we visited people recommending care in the medical care group ranged from 98% to 100%.

Across the trust, with regard to Friends and Family Test, the inpatient wards were ranked second out of 172 Trusts in January 2018 with a response rate of 18.9% which is above the national average of 15% *(National data)*

The patient –lead assessment of the care environment (PLACE) rated privacy, dignity and well-being at 88% in June 2017, in June 2016 it was rated as 80%. The national average was 83%.

**Emotional support**

*Staff provided emotional support to patients to minimise their distress.*

Throughout our inspection, we witnessed staff supporting patients, responding to their needs and communicating in an appropriate way. Patients had access to the palliative care team, the chaplaincy service and a broad range of specialist nurses to support them whilst they were inpatients.

We observed a stroke consultant providing reassurance and using touch appropriately for a patient who was drowsy. The consultant gently explained action they would take when the patient stated they were hungry, such as insertion of a tube in order to provide them with nutrition safely. There were similar observations of care and compassion from consultants and nurses in the AMU, treatment investigation unit (TIU) and ward 5.

The stroke unit held a group every Tuesday 2pm to 5pm for stroke survivors, their friends, carers’ and relatives, to provide ongoing support. A relative of a patient on the stroke unit told us ‘The team are really reassuring. It is difficult because you are anxious yourself – so you need reassurance’. The lung care nurse specialists provided a monthly support group to patients and their families who were undergoing complex investigations or had been diagnosed with cancer. In oncology the trust ran a course ‘Help Overcoming Problems Effectively’ (HOPE). This was a course for patients following cancer treatment and helps them to rediscover their strengths and overcome emotional and practical challenges with life after cancer.
Staff in the endoscopy department told us how they support patients in breaking bad news following a procedure, or test, where malignancy is found. There was a room available away from the main area where patients were supported by the doctors and nurse specialist. Staff told us they gave patients a little information at a time so they can absorb it, with follow up written information given including contact numbers for the specialist nurses and appointments.

A diabetes support group for young adults aged 16-20 with type 1 diabetes created in June 2017 and reported in the media as being “truly valuable”.

During the SOFI we undertook, we observed on both wards how calm and gentle staff were when emotionally supporting people living with a dementia who were agitated or distressed. The trust used ‘This is me’ booklets for patients living with dementia. Staff usually asked the patients next of kin or carer to complete the booklets, to ensure that staff had knowledge and insight into the patient behind the disease. However, on ward 25, short stay older people’s care, we saw two blank forms on notice boards behind patients’ beds. The patients in ward 25 had both been in the ward more than a week, one patient since the 25 February 2018. If staff had more awareness of a patient’s preferences, this may reduce the incidence of agitation experienced by patients living with a dementia, being cared for at the hospital.

Cancer services rated exceptionally well by patients in the national patient experience survey 2016. On a scale of zero to 10 with 10 being very good the service scored 8.9. This was reported in the media in July 2017.

Understanding and involvement of patients and those close to them

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

- Patients on the stroke unit were encouraged to do what they could for themselves ‘with my good hand I can wash my face’ and ‘staff cut my food up, and I can feed myself’.
- A stroke patient and their relative ‘The doctors we have met have been great and explained things to us.’
- A patient on ward 5 ‘not only look after the patients, but also the visitors.
- A patient in the coronary care unit ‘they actually talk to you’
- A relative on ward 9 – I have been away on holiday but I understand they have kept my brother up to date’ and ‘The staff have been very good at keeping me up to date with plans and the reasons for delays’.
- A patient in the endoscopy department ‘Fully informed. No sedation so I can take myself home. Just waiting for the report. They have told me the result, but waiting to have it in writing. Also told the doctor will telephone me in two days’.

On the stroke unit there was a notice on the notice about, prompting relatives to ask a member of staff if they would like to speak with a member of staff. A relative said to us, ‘the staff have kept me up to date all the time. I had a telephone call to arrange for me to come in and see the doctor. It was not just a chat, we met for about an hour, and that has happened at least twice’.

Patients we spoke with all confirmed that their treatment had been discussed with them and they felt able to make informed decisions.

Is the service responsive?

Service delivery to meet the needs of local people
The trust planned and provided services in a way the met the needs of local people.

The 52 bedded acute medical unit (AMU) was open 24 hours a day, seven days a week. Staff told us the unit was always busy and had alleviated pressures in the A&E department.

The service leads for older people medicine told us in 2016, they reviewed their patients’ pathway including delayed discharges. They also signed up to the acute frailty and weekly meetings set up including clinicians to improve the pathway for frail older people. The pathway has included the setting up of an older persons assessment unit (ward 26), an occupational therapist working in the emergency department and close integrated working with social services and the local authority. The senior team told us next steps were to develop seven days a week ambulatory services. To support with winter pressures ward 9 was opened from 2 January 2018 to 28 March 2018 to assist with the flow of patients.

The trust had set up a complex discharge ward, ward 5, which a consultant nurse led supported by a medical consultant and a junior doctor. This released beds on the older person’s wards for patients who were clinically unwell.

The trust had developed several services to meet the needs of people in the community who required medical intervention without the need for admission to hospital. This included the Treatment Investigation Unit (TIU) that undertook treatments that included infusions, for example blood platelets and pre and post biopsy care.

The stroke unit has the hyper-acute beds and stroke rehabilitation unit. The stroke service provided an early discharge team. This enabled patients to return home at an earlier point in their recovery to continue their rehabilitation with support from the stroke therapy team.

The endoscopy unit had four nurse endoscopists and an Irritable Bowel Disease (IBD) Specialist Nurse who consented and carried out procedures.

The medicine care group were involved in several quality improvement projects, utilising the Institute for Healthcare Improvement Model for Improvement based around plan, do, study and act (PDSA) cycles. The stroke nurse consultant and transient ischaemic attack (TIA) nurse specialist in January 2016 led an improvement project that involved the setting up of an ambulatory care clinic for stroke patients. Patients were assessed using the evidence based tool National Institute of Health Stroke Scale (NIHSS). The NIHSS enables staff to objectively quantify the impairment caused by stroke. Early findings were that for patients with 0-4 on the scale their average length of stay in hospital was reduced from 71 to 49 hours. For patients with an NIHSS score of 0-8 their average length of stay had gone from 79 to 68 hours. The availability of the clinic meant a reduced length of stay for this group of patients. This would then mean the service was more likely to have capacity for patient coming in with a stroke who needed inpatient care.

The cardiology leads had recognised an upgrade of the cardiac catheter laboratories was required in September 2016, to avoid the risk of patients having long waits for a particular cardiac intervention. The risk had been managed with an additional consultant being employed, and additional sessions being provided at the weekends and during the evenings. Refurbishment of the cardiac catheter laboratories started in January 2018, and was due to be completed in December 2018.

The gastroenterology department provided services that included outpatients, inpatients and endoscopy. The endoscopy department had improved processes in endoscopy administration resulting reduced waiting lists and better use of existing administration and clinical resources. The change in processes significantly reduced the number of internal telephone enquiries allowing
more time for patient contact. A nurse practitioner now running clinics with ‘straight to test’ model for fast track colorectal patients freeing up consultant clinic time.

The respiratory department provided services that included outpatients, inpatients and three bronchoscopy lists per week. This included a fast track GP service for urgent and suspected referrals. Where appropriate, patients may be called back to the clinic for further review, providing a fast track service for consideration of further investigation and treatment.

**Average length of stay**

**Trust Level**

From October 2016 to September 2017 the average length of stay for medical elective patients at the trust was 2.7 days, which is lower than the England average of 4.2 days.

Average length of stay for elective patients in:

- Cardiology is lower than the England average.
- Clinical haematology and general medicine is higher than the England average.

**Elective Average Length of Stay – Trust Level**

![Elective Average Length of Stay – Trust Level](chart)

*Note: Top three specialties for specific trust based on count of activity.*

For medical non-elective patients, the average length of stay was 6.2 days, which is lower than the England average of 6.6 days.

Average length of stay for non-elective patients in:

- General medicine is higher than the England average.
- Cardiology and geriatric medicine is lower than the England average.

**Non-Elective Average Length of Stay – Trust Level**

![Non-Elective Average Length of Stay – Trust Level](chart)

*Note: Top three specialties for specific trust based on count of activity.*

**Royal Bournemouth I Hospital**
From October 2016 to September 2017 the average length of stay for medical elective patients at Royal Bournemouth Hospital was 2.9 days, which is lower than England average of 4.2 days.

Average length of stay for elective patients in:

- Cardiology is lower than the England average.
- Clinical haematology and general medicine is higher than the England average.

**Elective Average Length of Stay - Royal Bournemouth Hospital**

![Elective Average Length of Stay Bar Graph]

For medical non-elective patients, the average length of stay was 6.2 days, which is lower than England average of 6.6 days.

Average length of stay for non-elective patients in:

- General Medicine is higher than the England average.
- Cardiology and geriatric medicine is lower than the England average.

**Non-Elective Average Length of Stay - Royal Bournemouth Hospital**

![Non-Elective Average Length of Stay Bar Graph]

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

The service mostly took account of patients’ individual needs. However, in the high acuity areas, staff did not always understand the need to move patients to a single sex area when clinically ready within 12 hours, to ensure their privacy and dignity.

The trust employed specialist dementia nurses that staff could access to provide support and guidance in caring for patients with dementia. A dementia action plan in place that included staff
training, environment, nutrition and support for carers. Dementia and delirium champions were implemented in older people’s medicine focusing on improving patient experience and care on the wards. This role is replicated across the organisation. Several actions completed, and the dementia lead regularly monitored those not completed.

The hospital had participated in the national audit of dementia that collected data from April 2016 to November 2016 and reported in July 2017. There was an audit question asking staff about the availability of personal information for people living with dementia. Fifty-two staff from the trust responded, 23% said they always had information, 42% most of the time and 35%, yes, sometimes. This data was similar to the national average. The trust has employed additional staff to support in the completion of ‘this is me’ alongside dementia training.

The trust had planned and undertaken changes to the wards, the AMU, and endoscopy to support people living with a dementia. This included large clocks with a calendar adjoining, and when we inspected these were all up to date. Toilet and bathrooms were colour coded with pictorial signage. However, there was no pictorial signage in the AMU. Staff also told us that bay nursing was embedded in all wards, that had been introduced at around the time we inspected in 2015.

The trust had planned and undertaken changes to the wards, the AMU, and endoscopy to support people living with a dementia. This included large clocks with a calendar adjoining, and when we inspected these were all up to date. Toilet and bathrooms were colour coded with pictorial signage. However, there was no pictorial signage in the AMU. Staff also told us that bay nursing was embedded in all wards, that had been introduced at around the time we inspected in 2015. This was where a member of nursing staff was based in a specified bay at all times to respond promptly to patients’ needs. This could include responding to call bells promptly, improved observations of patients’ general wellbeing and recognition and action in response to non-verbal signs that a patient required assistance. This was supported by the introduction of small desks in some wards within bays for staff to work at, and in others staff stood at other desks where they able to keep patients’ records up to date. The patient led assessment of the care environment (PLACE) for dementia care in June 2017 rated as 88%. The national average was 76%.

The trust dementia focus group noted the importance of recognising people who lack capacity. The older persons medicine team had introduced forget-me-nots to the patients name boards for those patients living with dementia as a subtle reminded to them. When we inspected there were forget-me-not signs on the patients name boards, except in AMU. Staff we spoke with were familiar with the symbol, except for one member of staff on ward 9, winter pressures, who not sure what the symbol meant.

Staff were able to care for people living with a learning disability. Patients’ living with a learning disability or autism were flagged electronically so staff were aware as soon as they were admitted. To support these patients during their admission the trust works collaboratively with the individual care agencies ensuring continuity of care. When we inspected there was a patient on ward 2 from a nursing home, receiving 24-hour support with their own regular carers. Staff from a nursing home for a second patient with a learning disability had brought in the patients sensory lights and foils. The dementia team and liaison psychiatry team also had access to patients’ community health records providing detailed information relating to patients ongoing needs and treatment.

We saw examples of individualised responsive care for patients with individual or complex needs during the inspection:

- Staff organised one to one care for people living with dementia who were distressed or confused, to provide comfort and reassurance.
- Patients’ at high risk of falls were seen wearing anti-slip red socks, to alert staff to the need to promptly support these patients’ if they should try and mobilise unsupported.
- In the stroke unit, part of therapy involved potting plants, to support patients’ rehabilitation.

The trust had employed a volunteer garden to support clinical staff with this patient therapy.
As part of a humanising care project the stroke unit arranged for ‘Pat dogs’ to visit three times a week to support patients in their physical and emotional recovery, and provided aromatherapy. Improvements as a result of the project also included individual care review meetings with patients’ and their families within seven days of admission, and a weekly ‘smoothie’ group for patients with a compromised swallow.

- On the older people’s medicine wards, the trust had arranged for monthly music concerts to help entertain and socialise patients.
- In the Jigsaw building the staff ran workshops “Look Good, Feel Better workshops for women diagnosed with cancer”. The workshops run on a monthly basis and teach women a skin care regime to help them feel better.
- A complimentary therapies service has been running for over a year in the Jigsaw building. Patients and their carer’s are offered free complimentary therapies including massage, hand and feet massage and reflexology.
- Oncology outpatients with high outpatient attendances are exempt from parking charges.
- Privacy and Dignity campaign – provided patient feedback on care, with ‘Dignity Stars’ highlighting exemplary care and ‘Dignity nudges’ highlighting areas for improvement.
- The Trust has employed a social worker attached to the oncology unit to support patients’ with psychological, financial and well-being needs.

The ward staff were able to access a telephone interpreting service for communicating with patients who did not have English language skills.

Patients and relatives had access to chaplaincy service including those from different denominations. The Chaplaincy consisted of a team of trained hospital chaplains from different faiths, which included Christianity (including Roman Catholic) Muslim, Hindu and Jews. If a patient required a chaplain of a different faith, staff were able to access this. The Chaplaincy team provided a 24-hour emergency call out service and they held a register of other faith leaders who could attend in an emergency as required. The trust also had 50 spiritual care volunteers six days a week providing spiritual and faith care to those that requested it.

The trust reported four mixed sex breaches from December 2016 to November 2017 and they occurred in the critical care unit, so none in the medicine service. The trust told us the compliance was due to them meeting with the local agreement set out in the trust privacy and dignity policy which stated -

‘When the physician has indicated that the patient is ready to leave the high acuity area, the ward need to contact the clinical site team (CST) to identify a bed to move the patient to. This then commences the clock ticking to avoid any potential mixed sex accommodation. The clinical site team will be responsible for monitoring the timeframe to relocate the patient to avoid any mixed sex accommodation occurring.’

Although in the medicine service patients with a high acuity were grouped together in designated bays with appropriately skilled nurses, at times patients that no longer needed this level of care remained in these bays. Department of Health mixed sex accommodation guidance states that as soon as patients’ that no longer need high acuity care, they should be moved to single sex accommodation. Staff did take actions to maintain privacy and dignity of patients in the high acuity bays that were mixed sex.

The stroke governance meeting dated March 2018, evidenced that three patients were recorded as being in hyper acute stroke unit longer than clinically necessary, which meant there were
undeclared mixed sex breaches. At the time of our unannounced inspection on 27 March 2018, in the four bedded bay there were three patients who were all male and one empty bed. Staff working in the stroke service were planning to review their policy, and update the standard operating process.

Staff took action to preserve the privacy and dignity of patients being nursed in mixed-sex, high acuity bays. These patients presented as very unwell and needing high levels of care. The trust had a high acuity bay in the AMU, and specialty high acuity bays in ward one gastroenterology and ward two the acute lung unit. At our inspection there were five patients in the AMU five bedded high acuity bay. There were males and females in the bay, who met the trust criteria for admission in place for the high acuity bay. We observed that male patients placed opposite male patients, and female opposite female patients’. The fifth bed did not have a bed opposite. Staff had also positioned the curtains so patients turning to their side in bed, were not directly facing patients’ of the opposite sex.

In ward one, gastroenterology, when we inspected the four patients in the high acuity bay were all male, who met the agreed criteria for patients’ needing care in the bay. Staff told us that if there should be male and female patients, they would be placed so same sex patients would be opposite each other, and curtains used so patients’ turning to the side would not see patients of the opposite sex.

Overall, the use of high acuity bays was deemed to be positive as patients received increased levels of care but remained in their specialty environment. However, the trust was aware of how this compromised single sex accommodation and they were developing workable strategies to mitigate the risks of nursing patients in this way. Matron told us some of this related to staff’s understanding of reporting responsibilities when breaches occur and there was some work going on to improve this.

Following our inspection on 13 and 14 March 2018, the matrons and head of nursing recirculated the privacy and dignity policy. They had all discussed the policy with ward teams to reaffirm the process. The privacy and dignity policy was also being reviewed in line with changes that were being made to introduce a new electronic bed system. The trust had also reviewed their complaints and patient survey data which showed there had not been any concerns from patients about mixed sex accommodation.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit and treat patients were in line with good practice. The trust had systems in place to aid patient flow, that included bed meetings that were increased in frequency if there were concerns about the demand for capacity. A proportion of patients experienced a delayed discharge.

Patients accessed the hospital through planned admissions directly to the relevant wards or departments, via the accident and emergency department or straight from outpatients including the X-Ray department. Patients arriving in accident and emergency were added to the patient electronic database. This meant patients were tracked throughout their stay in hospital.

The trust held twice daily operational meetings where the patient flow management for the day discussed. During our inspection we attended this meeting where senior executives were present and observed a useful, efficient meeting which managed patient flow proactively. Information discussed at the meeting including updates from partners such as the ambulance service and staffing. An action from the meeting was a media alert to the public to choose how to access
healthcare well, informing them of the pressure at the hospital. At the time of this meeting the trust was at operational pressures escalation level (OPEL) 4. Within this national framework, OPEL 4 indicated escalating major operational pressure, due to the number of patients requiring admission to the hospital.

During the meeting the number of medical outliers were discussed. A medical outlier is when a patient is not placed in the appropriate ward. Either the older people’s care physician of the day or the physician of the day on the specialty wards reviewed outliers daily. This sped up the process of clinical review of patients. Although ward staff told us the system in place worked well for patients, at times there could be a lot of medical and therapy staff on the wards at the same time for ward staff to co-ordinate. On the first day of our short notice inspection 13 March 2018 there were 40 outliers. From 1 February 2018 to 31 March 2018 the number of outliers ranged from zero to 43, the average was 16 each day. The trust was able to demonstrate that through quality improvement work there had been a significant reduction of 42% in the number of outliers during the periods from September 2016 to November 2016 (2415 outliers) and September 2017 to November 2017 (1401 outliers).

Most patients and relatives we spoke with were aware of plans to get them ready to go home. Ward and department teams started patient discharge plans on admission. We observed discharge planning being discussed at the daily board meetings and multidisciplinary teams working together to ensure all aspects of discharge were covered and planned for. Also, work streams were in place to improve the timeliness of discharge medicines

From December 2016 to November 2017 there were 2150 patients’ whose transfer from hospital was delayed. The longest patient wait for completion of a social worker assessment was recorded as 12 days with Hampshire social services. The longest wait for transfer to a local authority funded care home was 52 days (Hampshire). The longest wait for a local authority funded domiciliary package of care was 28 days from Bournemouth social services. The trust’s greatest concern was waiting times for Hampshire patients awaiting community hospitals or early supported discharge. The trust commented that stroke patients in particular experienced significant delays to access stroke beds at one of the local hospitals for their ongoing rehabilitation and management.

The trust had several initiatives in place to help access to services for patients, their transfer to the most appropriate services and to try and minimise waiting times. These included:

- A Stroke Outreach team to ensure patients were assessed by a specialist nurse quickly and could spend the majority of their stay on the stroke unit.
- Patients having an endoscopy procedure had their admissions times staggered to support reduced waiting times.
- Patients were directly admitted to specialist wards. When we inspected on ward 2, a patient had admitted direct from X-ray who had a long term lung condition.
- Staff we spoke with confirmed that patients usually were only in the AMU up to 48 hours, thus creating capacity for new patients being admitted.
- The wards had discharge co-ordinators incorporated into their staffing templates, who were focussed on ensuring patients discharges plans were progressed every day. The trust held a weekly meeting with partners on a Monday to discuss patients whose discharge delayed.
- The treatment investigation unit would administer the last dose of intravenous antibiotics to support patients’ discharge if needed. This was not a common occurrence.
The trust worked hard to ensure that patients received timely access to treatment.

Referral to treatment (percentage within 18 weeks) - admitted performance

![Graph showing referral to treatment (percentage within 18 weeks)](image)

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>99.6%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>99.3%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>93.6%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.3%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for admitted RTT (percentage within 18 weeks).

(Source: NHS England)

We also reviewed trust figures for RTT times for cardiology. From April 2017 to November 2017 they ranged from 96 to 97%, for February 2018 and March 2018 the RTT was 94%. For these specialties the RTT were all above the national target of 92%.

Learning from complaints and concerns

The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff.

The trust senior clinical teams monitored and discussed complaints at their directorate governance meetings.

From October 2016 to November 2017 there were 105 complaints about medical care at this trust. Complaints were all acknowledged within three working days. The target set by the trust to investigate and send a response to the complainant was within 25 working days, 81% of complaint responses were meeting this target. The two main types of complaints categories were patient care, including nutrition and hydration (57), and communication (20). Twenty of the complaints about patient care were fully upheld and four of the complaints about communication were fully upheld. Trust wide, three complaints were referred on to the Health Service Ombudsman.

Lessons were learned following complaints. For example, following a complaint about Continuing Healthcare (CHC), the trust now ensure nursing staff had the knowledge and skills to complete
CHC records for patients. The discharge services intranet page has been updated to enable clinical staff to access CHC guidance when required. A CHC education and training has been set up with Dorset CHC team and the trust education department.

Staff told us they tried to resolve patients’ complaints directly at ward and department level before the complaints escalated. Staff knew how to direct patients’ or their relatives to the patient liaison service (PALS) if they wanted to make a more formal complaint. The wards and departments had leaflets in racks on the wards and on their website, to support patients’ or their relatives who wanted to make a formal complaint.

### Is the service well-led?

#### Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high quality sustainable care.

The trust divided the management of services into three care groups, medical services were care group ‘B’. The care group was formed of three directorate specialisms, cardiology, medicine and older people’s medicine. The care group also included the heads of therapies for outpatients and inpatients. We saw many examples of where quality improvement projects were driving improvement of the service.

Senior staff including the executive team were all visible and engaged with staff on a regular basis. Trust leaders had an open door policy for staff and patients.

The trust had invested in bespoke development at care group level and in a matrons development programme. Staff, including band 6s, were going on management development programmes. Leaders also supported unqualified staff. An example included healthcare assistants on ward 24, a short stay older persons’ ward had been sponsored to undertake her nurse training.

The medical care group had a director of operations, a head of nursing and quality and a care group medical lead. Each directorate had a clinical director, a general manager and matron support. Whilst on inspection we met with the director of operations, head of nursing and quality and representatives from the older people’s medicine team to gain an understanding of local leadership within the trust. We reviewed minutes of meetings, the risk register and reports to gain an understanding of how leadership functioned with medicine at the trust.

Patients could easily recognise ward and department leaders as they wore dark blue uniforms, and more senior nursing staff including matrons wore red uniforms. Staff knew the matrons well and felt they supported by them. Staff on ward 9 commented that the director of nursing had been visible on the ward since it opened in January 2018. Senior staff were also working well with other trusts to develop services, in line with the clinical services review.

#### Vision and strategy

The trust had a clear strategy for the period 2015 to 2020 to ensure the maintenance of high quality sustainable clinical services. The trust launched a new vision in January 2018 to work in partnership and continually improve our services.

The trusts vision and strategy and operational priorities were incorporated into the way the three directorates in the care group were taking their services forward. This included initiatives such as enabling closer joint working with neighbouring trusts and partners and seven day a week ambulatory services.
The trust board and senior leaders of medical care were highly committed to ensuring that the clinical services review was successful and improved care for the local population. Staff were expecting the trust to merge with a neighbouring trust within the next 18 months.

Staff we spoke with knew how their work contributed to the wider vision of the trust and they were aware of the trust’s values. Staff told us how the trust’s vision and strategy was included in new staff’s induction training and the trust’s values were embedded in their practices. The trust’s values of pride, communicate, improve and teamwork were displayed on the medical care wards and departments notice boards and on staff name badge lanyards.

Culture

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

Staff from all medical wards and departments we visited told us of the excellent teamwork amongst their colleagues. We also observed excellent team working focused on achieving best outcomes for patients during our inspection in all the wards and departments we visited. Staff were open and honest that staffing shortages did sometimes make work challenging, especially when redeployed to other wards. However, there was a great sense of team working and pulling together. We noticed measures in place to support working together included the six matrons in the care group from the three directorates meeting briefly at 9am to discuss briefly current challenges and issues they were addressing.

In May 2017 the trust held a diversity and inclusion week. This was co-designed by change champions and interested individuals. Staff used the trust engagement trolley to canvas the views of 200 staff across the whole trust. This supported senior leaders to ensure the trust responded appropriately to staffs’ needs and wishes relating to diversity.

Staff wanted to tell us how positive and proud of the hospital they were. Many of the staff were local to the area and were keen to tell us that the hospital was an important part of the local community.

The trust won the Health Service Journal award for staff engagement 2017 for their culture change through change champions. We found a culture of continuous improvement was embedded when we spoke with staff in the wards and departments, frequently thinking about how things could be improved. This included simple changes that make a difference which we observed in AMU, such as isolation sign making it clear what types of personal protective equipment were needed if visiting a patient who was being cared for in a single room for isolation purposes. There were also much larger quality improvement projects, for which large posters had been produced advising on quality improvements made by staff. Staff we spoke with consistently reported feeling empowered to make improvements in their everyday work.

As per NHS guidelines, the trust had a freedom to speak up guardian (FTSUG) whom staff could talk to if they had concerns. The FTSUG role was well embedded at the trust. Since April 2017, and following the formal launch of FTSUG in September 17, 34 concerns have been raised. When we spoke with staff they were aware they were aware of the FTSUG role. Of those cases raised trust wide, 68% were related to attitudes and behaviours and 12% relating to policies. The data submitted to the National Guardian Office in from July to September 2017 also highlighted that 38% of concerns raised had an element of patient safety.

Staff we spoke with were aware of the whistle blowing policy, and were confident to use if they needed to.
Governance

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

Each speciality in the medical service care group held monthly or every other month clinical multidisciplinary governance meetings using a set agenda. Having a set agenda ensured that key quality issues of safety, risk, clinical effectiveness and patient experience were discussed and standardised across services. Each care directorate had their own medical clinical governance lead. Information from these meetings was escalated through the quarterly care group governance report and the monthly quality assurance risk committee. These governance processes ensured there was ward to board assurance.

Managers discussed the quality of services at clinical governance meetings. A range of data used to monitor services including adverse incidents, compliance with electronic nursing assessments and patient experience feedback.

Senior staff told us information from meetings was disseminated down to staff in various ways, ward meetings, during handovers or ward safety huddles, the hospital intranet, emails, newsletters and information displayed in staff rooms. We observed this in all the medical wards and department during our inspection. Following the never event in medicine, staff we spoke with could tell us about the changes that had been implemented.

Management of risk, issues and performance

The service had a system for identifying risk, planning to eliminate or reduce them and coping with both the expected and unexpected. However, since May 2017 trust wide there had been six never events, one of these had been in the medicine service.

There was local risk register covering the whole medical group. There was a process in place for risks to be placed on the risk register. This started with discussion within the clinical governance groups.

At the time of the inspection there were 19 risks on the risk register relating to the medical service. The risk register included a date of when the last review was and when the next review was due.

When we reviewed the clinical governance meetings records within the directorates, a standard agenda item was a review of the risk register. All the risks had been reviewed regularly, and actions were being taken and monitored to lower risks. There was one red rated risk relating to the medicine service, which meant the risk was significant. The risk was described as ‘urgent care front door and flow’. This risk was also on the trust wide risk register. This meant the trust board were also sighted on the risk, and provided support to manage the risk. This showed the trust had effective mechanisms in place to escalate risks appropriately from ward to board.

Senior nursing staff in the wards and departments, reviewed all learning event report notification (LERN) forms, which staff created following incidents on their incident reporting system. They identified areas for learning and sharing to improve practices. The trust introduced the LERN forms in February 2017, under the Share to Care initiative, replacing adverse incident reporting. They were developed for staff to report when something has gone well, as well as to report incidents or concerns, or to suggest an improvement.

The trust had a major incident and response plan. Emergency plans and procedures clearly identified what measures would be required from the medical wards and departments. Staff we spoke with were aware of the major incident and response plan and understood their roles within
it. Staff were used to working in a flexible way and were able to safely prioritise any new admissions.

**Information management**

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

The trust used a quality dashboard, that included a range of metrics including compliance with the completion of patient electronic nurse assessments and staff appraisals. If a ward or department meeting the target set this would show as green, if not amber or red depending on how far away a ward or department was from the quality target set by the trust. Senior staff put action plans in place if their ward or department was not meeting a quality target.

Alongside the quality dashboard the trust used a monthly dashboard to monitor performance. This included performance in national, commissioning and internal targets. The care group’s performance was rated to provide a clear indication of where performance not at target. When we spoke with senior staff from older people’s medicine, they told us the directorates within the care group had monthly management meetings that were multidisciplinary. Where targets were not being met, these would be discussed and forward plans determined. For example, in older people’s medicine, there had been discussions about falls prevention and actions to ensure the occurrence of falls was minimised.

**Engagement**

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

Patients were encouraged to complete regular surveys to provide feedback on the trust performance. Themes of concerns and complaints and feedback of the friends and families test were scrutinised.

The medical care group had held various patient and public events. These included an inflammatory bowel disease education morning in March 2018 in line with inflammatory bowel disease standards (2013). This included a patient panel. Sessions were also held for the public to engage with expert staff at the trust. The next two sessions planned with a gastroenterologist in April 2018, and a dermatologist in June 2018.

The diabetic centre provided an award winning education programme, Bournemouth Type 1 Diabetes Education Programme (BERTIE) that is a four-week course for people with type 1 diabetes. This involved participants attending a six-hour group education programme once a week for four consecutive weeks. The time between sessions was used for participants to put their newly learned skills into practice. The department had undertaken audits following people attending the course. Results showed that over 80% of participants met their own goals relating to their diabetes, over 95% of participants reported they benefitted from attending the course and many participants went on to have less low blood sugar episodes.

Focus groups with the public were taking place within the care group. Within the care of medicine for older people, focus groups were held to facilitate the best way of maintaining the identity of people as they become older and frail. The endoscopy focus group feedback centred round the waiting area and the need for a television. As a result, the endoscopy department secured charity funding with plans for purchase and installation.

The stroke service was involved in a Dorset wide patient and public experience group with an established framework for patient and carer involvement. (level 1 - home based involvement, level
2 - interviews and focus groups, level 3 - patient partners, level 4 - co-chairs). There was an active database recording details of patients and carers expressing an interest in being involved. At the time of our inspection, they were undertaking level 2 forums across Dorset.

The trust conducted a local staff survey entitled ‘staff impressions’ since 2014. In 2014 73% of staff were recommending the trust as a place for treatment. In 2017, the percentage had risen to 89%. In the 2017/2018 survey for the period from July 2017 to September 2017, the trust focussed on freedom to speak up (FTSU) questions to support the launch of their in house FTSU guardians. The results were positive and have shaped the FTSU guardians role. There were some themes for improvement highlighted around the need to listen more; staff feeling stretched, a desire to feel valued and to recognise mental health and well-being issues and wanting more opportunities for development. Staff we spoke with told us how valued they had felt with the thanks from the trust for efforts made to get to work and keep the service running after a period of heavy snow. A porter told us how valued they felt when receiving a letter from the director of nursing commending them for their good attendance during their service at the trust. The stroke service awarded a monthly ‘star of the month’ award to team members. The January 2018 award was given to a therapy assistant ‘who frequently stepped in to support the ward staff and had such a sunny, smiling way with patients. Well done’.

In the latest national staff survey published in 2017 the trust had a response rate of 46% against an average response rate of 45.5%. The trust out of 48 other acute trusts out of 88 questions scored significantly better than average on 76 questions, significantly worse than average on zero questions and the scores were average on 12 questions.

Learning, continuous improvement and innovation

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

The trust had held an annual patient safety and quality improvement conference in September 2017, for all staff, as part of their quality improvement programme. This was used to share staff-led improvement initiatives.

Several staff at the trust had won individual awards, or been short listed for national awards;

- A haematology consultant at the Royal Bournemouth Hospital (RBH) has been named Inspirational Woman in Science and Technology at the 2017 Dorset Venus Awards. They were awarded for their dedication to science. The haematology consultant led a team of scientific and clinical researchers committed to innovative research, with the aim of improving survival rates and the quality of life of patients with blood cancers. In addition to this, their clinical work and being a mother, the consultant is also a trustee for a national charity for patients’ with Waldenstrom's Macroglobulinemia, a rare type of cancer, and was instrumental in fundraising for the new Orchard Therapy Garden at the trust

- An advanced nurse practitioner in urology, was awarded third place for Urology Nurse of the Year in the British Journal of Nursing Awards. They were nominated for her work expanding the role of healthcare assistants in the team and her contributions to urology nursing.

- The trust’s stroke team was shortlisted for the Health Service Journals International Health Partnership Award. The team has been collaborating with the Wessex Ghana Partnership since 2009 with funding from the British Medical Association, The Royal College of Nursing and two grants from the Tropical Health Education Trust. The partnership has enabled the
team to visit Korle Bu Teaching Hospital in Accra, Ghana, and support them to develop their stroke care.

- A diabetes education forum designed and relaunched last year by the Diabetes Team at the trust won a national award, Best Learning Technologies Project’ in December 2017. BERTIEonline, an online platform offering structured education for people with Type 1 diabetes, was selected as a finalist in the ‘Digital and Technology Solutions in the Treatment or Management of Diabetes’ category in the Quality in Care (QiC) Diabetes 2017 Awards. The portal offers vital education via an innovative and unique platform and also provides a forum for people to share their experiences and build a support network – ideal for those who have recently been diagnosed and may be feeling alone and overwhelmed.

As part of continuous improvement initiatives, a senior nurse in cardiology was trialling with patients a chair that could be reclined to a trolley if required. The purpose was to help patients to feel more independent and ambulatory rather than trolley bound. The outcome of the trial was not known at the time of our inspection. A nurse endoscopist was planning to set up a Barrett’s oesophagus self-help group. The nearest support group was currently at Southampton.
Royal Bournemouth Hospital provided elective and emergency adult orthopaedic surgery, which were all part of the surgical services, care group.

Surgical specialties included general (breast, upper and lower gastrointestinal, urology and vascular surgery). The trust was the hub for regional vascular and urology (including robotic) services and for some upper gastrointestinal cancer surgery. There were five surgical inpatient wards and day case environments. There was a short stay unit (Ward 12), a surgical admissions unit and an ambulatory emergency care centre for surgical patients. Sandbourne Unit was a day treatment unit for surgical and orthopaedic patients.

Trauma and elective orthopaedic services were shared between a neighbouring NHS trust and Royal Bournemouth hospitals, with trauma services based at the other trust. Elective orthopaedics at the Royal Bournemouth were provided on two wards; ward seven (12 beds) which provided care for more complex elective orthopaedic cases and Derwent. Derwent was a dedicated primary joint replacement unit (of 20 beds serving two theatres). Spinal surgery was provided at a neighbouring NHS hospital.

Pre-operative education classes had been established for patients having hip and knee replacement surgery, and formed part of their preoperative preparation for surgery.

An emergency theatre was available 24/7 in line with the National Confidential Enquiry into Peri Operative Deaths (NCEPOD) recommendations. There were 17 theatres within main theatres, Derwent, day surgery and the day treatment centre - Sandbourne.

The trust has 12 surgical wards, which specialised in:

- Day surgery unit
- Two elective Orthopaedics
- Emergency surgical admissions
- Anaesthetics
- Ophthalmology
- Trauma and orthopaedics
- Colorectal/breast surgery
- Emergency admissions
- Vascular surgery
- Upper gastro intestinal /bariatric
- Urology/gynaecology
- Ambulatory emergency care
- Oral surgery
- Women’s health
- Orthopaedics
• Ophthalmology
• Private patient facilities (these were not inspected)

The trust had between 179 and 197 surgical inpatient beds, depending on the season.

(Source: Routine Provider Information Request (RPIR) – “Sites-Acute” tab)

The trust had 37,801 surgical admissions from October 2016 to September 2017. Emergency admissions accounted for 7,013 (19%), 23,124 (61%) were day case, and the remaining 7,664 (20%) were elective.

(Source: Hospital Episode Statistics)

During this two-day inspection, we spoke with twenty patients and relatives and sixty-two members of staff. These included nursing, medical, theatre, therapy and senior management staff. We reviewed twenty sets of patients’ records, 16 medicine prescription charts. We undertook seventeen visits to wards, theatres and surgical departments. We received 60 patient comment cards.

Is the service safe?

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

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

Mandatory training

The trust provided mandatory training in key skills to all staff and monitored staff compliance. The trust target for compliance was not met by surgical medical staff.

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of November 2017 for medical and dental and nursing and midwifery staff in surgery is shown below:

Mandatory Training Completion by module – Medical Staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity &amp; Human Rights</td>
<td>95%</td>
<td>121</td>
<td>133</td>
<td>91%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>95%</td>
<td>120</td>
<td>133</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>WRAP Training</td>
<td>95%</td>
<td>118</td>
<td>131</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>119</td>
<td>133</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Security, Violence &amp; Fraud</td>
<td>95%</td>
<td>119</td>
<td>133</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>95%</td>
<td>117</td>
<td>131</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Sharps-Level 2</td>
<td>95%</td>
<td>118</td>
<td>133</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>95%</td>
<td>116</td>
<td>131</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>112</td>
<td>127</td>
<td>88%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>117</td>
<td>133</td>
<td>88%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (including Privacy &amp; Dignity standards)</td>
<td>95%</td>
<td>116</td>
<td>133</td>
<td>87%</td>
<td>No</td>
</tr>
</tbody>
</table>
The medical staff within the surgical services care group did not meet their mandatory training target for any of the 18 mandatory training modules. The two lowest compliance scores were 68% for fire, and 22% (two people trained) for Level 3 intermediate life support although only nine staff were eligible to be trained in this.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>327</td>
<td>328</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>332</td>
<td>334</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security, Violence &amp; Fraud</td>
<td>95%</td>
<td>332</td>
<td>334</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Sharps-Level 2</td>
<td>95%</td>
<td>328</td>
<td>330</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>95%</td>
<td>321</td>
<td>324</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>95%</td>
<td>319</td>
<td>327</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity &amp; Human Rights</td>
<td>95%</td>
<td>324</td>
<td>334</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>323</td>
<td>334</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>95%</td>
<td>319</td>
<td>330</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>322</td>
<td>334</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>95%</td>
<td>317</td>
<td>331</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>95%</td>
<td>636</td>
<td>665</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>WRAP Training</td>
<td>95%</td>
<td>312</td>
<td>331</td>
<td>94%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>311</td>
<td>330</td>
<td>94%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>440</td>
<td>472</td>
<td>93%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia-Tier 2</td>
<td>95%</td>
<td>296</td>
<td>321</td>
<td>92%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>95%</td>
<td>280</td>
<td>316</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>286</td>
<td>329</td>
<td>87%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>260</td>
<td>326</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>95%</td>
<td>260</td>
<td>334</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3-Adult Immediate Life Support</td>
<td>95%</td>
<td>8</td>
<td>16</td>
<td>50%</td>
<td>No</td>
</tr>
</tbody>
</table>

The nursing and midwifery staff did not meet their target for nine of the 21 mandatory training modules. The two lowest scores were the same as for the medical staff although fire was 78% and Level 3 intermediate life support was 50% (eight people) of the 16 eligible to be trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

On inspection, many of the staff we spoke with told us that the ward administration assistants monitored and booked ward staff onto mandatory training. Staff compliance formed part of their individual performance review or appraisal. Without their mandatory training being completed staff were unlikely to be supported by their managers to access other education.

The trust also provided training for the recognition and treatment of sepsis in different formats, including ward based, lectures and simulations. Specific sepsis training was aimed at all first year
Safeguarding

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

Safeguarding aims to protect people from avoidable harm or abuse. The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of November 2017 for medical and nursing and midwifery staff in surgery is shown below:

### Safeguarding Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>119</td>
<td>133</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>116</td>
<td>130</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>118</td>
<td>133</td>
<td>89%</td>
<td>No</td>
</tr>
</tbody>
</table>

This staffing group met the target completion rate for one of the four safeguarding training modules.

### Safeguarding Training Completion by module – Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained (YTD)</th>
<th>Number eligible (YTD)</th>
<th>Completion (%) YTD</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>332</td>
<td>334</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>327</td>
<td>329</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>328</td>
<td>331</td>
<td>99%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

This staffing group met the target completion rate all of the four safeguarding training modules.

(Source: Trust Provider Information Request P18)

The trust had safeguarding leads in directorates across the trust; the trust executive lead for safeguarding was the Director of Nursing and Midwifery. There were internal and external meetings in the trust to ensure appropriate escalation of safeguarding issues took place. Staff we spoke with were confident of the process for raising safeguarding concerns and who their local leads were.

Cleanliness, infection control and hygiene

The service controlled infection risk well. They used control measures to prevent the spread of infection. Clinical cleaning compliance was not consistent.

We observed the staff observing bare below the elbows when working in clinical environments. The staff’s compliance with hand hygiene for the surgical wards between November 2017 and
February 2018 was 94% to 98%, showing as amber. The staff wore clean uniforms and most wore appropriate personal protective equipment such as gloves and aprons when dealing for example, with bodily fluids. There were adequate soaps and hand gels located in wards and departments in line with WHO five moments of hand hygiene. Visitors were encouraged to clean their hands on entering the hospital to prevent spread of infection with large signs and hand gels. We saw posters displayed at the entrance of the wards to advise visitors of infection prevention measures.

The trust did not have an electronic means of tracking and tracing patients with infections, there was work ongoing with the IT department to design an in house system.

Most wards appeared visually clean, although there was some variation in cleanliness of the ward floors. The trust monitored environmental cleanliness monthly or quarterly and we saw that average annual compliance from March 2017 to February 2018 was between 91% for a reception area and 99% for theatres. We reviewed the wards clinical cleaning records, which detailed that regular clinical cleaning was taking place. However, we noted there were some ward areas where clinical cleaning was not recorded as completed consistently. For example, one ward had not had cleaning records completed since November 2017, on this ward there was grey dust found on some of the clinical storage trolleys. Another ward had a build-up of grey dust on the patient records trolleys. The trust monitored compliance with clinical cleaning and these wards had scored 100% consistently between March 2017 and February 2018. This meant that the monitoring process was not always reliable in picking up deficits.

In theatres, there were systems and processes aimed to provide assurance that cleaning had taken place, including gas circuits and filters. We saw that there was a clinical cleaning rota; however, there were gaps in cleaning with no reasons for their omission given. Again, theatres scored highly on the compliance monitoring between 99% and 100%, which did not reflect what we saw on inspection. Theatres also had an extensive detailed cleaning assurance list, which covered for example, anaesthetic machines, cleaning of trolleys and checking of controlled drugs. On this list for the month of January 2017, the cleaning compliance ranged from 100% to 56%. For high risk of infection cases such as joint replacement surgery, laminar flow theatres were available to minimise the risks to the patient. The sterilisation of instruments sets had been problematic recently, staff told us that some sets were received for theatre cases with debris attached, and this had meant some cases were delayed or cancelled. There was ongoing testing of the instruments to ensure they were contaminant free.

There were cardboard boxes stored directly on the floor of some ward storerooms, which did not allow effective cleaning to be undertaken. There were also toiletries left in some of the bathrooms for access by multiple patients. We saw that many sluice (dirty utility) rooms also stored new, clean items for patients’ personal use, for example, incontinence pads and single use toiletries. The normal function of the sluice meant that clean items might be unintentionally contaminated.

The wards utilised disposable privacy curtains and we saw that they were changed within three months prior to the inspection and were clearly dated.

Some sluice rooms were very small and staff had made significant efforts to keep the areas clean and clutter free. We saw some two-bed bays, which looked as if the spacing was restricted and potentially compromised infection prevention bed space guidance. Staff we spoke with told us the trust had checked the bed spacing; however, the trust provided us with a risk assessment completed after our visit. The bed spacing was checked against compliance to Health Building Note 00-03 on 27 March 2018; further risk assessments for manual handling and infection control were yet to be undertaken.

Some surgical ward bays were fitted with portable single isolation bays, known as ‘Icepods’ to provide adequate segregation of patients for infection prevention and control purposes. These
additional bays were provided due to the limited numbers of single rooms on some wards. Other wards such as the Derwent unit only had single rooms, which was ideal as elective orthopaedic joint replacement patients are at high risk of infections.

The trust monitored the wards’ use of antibiotics by formal antimicrobial stewardship, the lead microbiology pharmacist logged ward reviews on a database. Ward pharmacists reviewed most prescription charts daily. The consultant microbiologist and lead pharmacist monitored and logged all antimicrobial prescriptions for appropriateness and accuracy. We were shown the 2017 audit summary for surgery; this had five standard criteria which prescriptions were measured against. There was good compliance for documentation, for the course length and for the review of antimicrobials with 72hrs of prescribing. However, the audit summary showed poor results for the duration stop date being documented and a documented reason for the antibiotics. The audit showed that prescribing achieved average compliance against trust guidelines. The audit summary did not include any identified actions for improvement.

The trust had a sepsis management pathway to reduce the risks of sepsis to patients, and monitored the compliance. The latest compliance of the delivery time of antibiotics to patients with confirmed sepsis were; within one hour 72%, within four hours 100%.

Surgical site infections were monitored by Public Health England, the trust contributed data relating to a variety of surgical procedures. These included, limb amputation, small bowel surgery, vascular surgery, gastric surgery and joint replacements. Some of these results appeared to show concerns in infections in some cases, but there were very small numbers compared to the national average. For example, two or 3.2% inpatient or cases readmitted of limb amputations were infected, the national average was 2.8%. There was a slightly higher than national average infection rate amongst knee replacement surgery.

The trust had a large nurse led pre-operative assessment service that assessed patient’s fitness for surgery. As part of the assessment, high-risk patients such as orthopaedic joint replacement had routine screening for the presence of MRSA. If they were positive, they received treatment prior to surgery.

There was a robust waste management policy and appropriate segregation of waste in line with the policy. We noted that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff followed guidance on sharps management, which included no re-sheathing of needles. The sharp bins were clearly labelled and tagged to ensure appropriate disposal and to prevent risk of cross infection.

**Environment and equipment**

The surgical services used mostly suitable premises and equipment and looked after them well. Some wards were an unconventional lay out and there were no secure doors on most clean utility rooms.

Some wards faced challenges from their physical environment. Staff told us that patient ‘outliers’ or patients moved from their speciality due to bed pressures, were often cared for in an environment that was not ideal. Staff we spoke with showed us areas where they had concerns, for example, adult patients placed in an empty paediatric bay in the eye ward. The different needs of some outlying patients were not always fully accommodated by the ward facilities. For example, limited assisted toilets and mixed sex facilities meant that staff were constantly trying to meet the outlying patient needs appropriately.
We saw other wards, which were unconventionally laid out, with split specialities meaning that staff were often challenged in caring for the patients’ safety. This layout had happened when parts of the ward were sectioned off for other services. The facilities and lines of observation in this area were limited but staff worked in separate teams to ensure that complex post op orthopaedic patients were safe, as were the frail elderly patients on the other side of the ward.

Across the trust, we saw that most clinical rooms in the surgical wards had no doors, and those that had a door were always propped open. Staff we spoke with told us that there had been recent risk assessments and it was agreed to keep the medicine and intravenous fluids cupboards secure inside the rooms. We saw that some cupboards in these areas were not locked even those that contained needles and other high-risk items. One area also had an unsecured medicine fridge. We asked the trust for a copy of the risk assessment and saw that it was carried out following our inspection. There were actions to review the storage of needles and syringes into locked cupboards as a result.

Within the unsecure sluices were lockable cupboards for the storage of items covered by the Controls of Substances Hazardous to Heath (COSHH), on some wards these were found unlocked. One ward had a cleaner’s trolley left unattended with bottles of bleach spray hanging on it, the cleaner’s cupboard on this ward was also unsecured.

The Derwent Unit had a difficult disposal route for dirty laundry; the bins were located down an outside path. The nursing staff had to carry bags outside to the bins; trolleys were not routinely used to lift linen into the disposal bins. We asked if this had been risk assessed and we were shown the risk assessment for new storage bins which were being provided. The risk assessment did not include any reference to moving and handling safety.

The resuscitation trolleys were tamper evident and were checked daily for any evidence of opening, once a week the trolleys were opened to check expiry dates. We saw that throughout the surgical wards and departments the trolleys were checked routinely.

Most wards and departments had individual resuscitation trolleys; there were a few exceptions where some were shared between wards. Some alternated their location every three months, and others were permanently located on an adjoining ward. This meant that the ward without the trolley was not involved in checking the equipment, which may not be located as easily in an emergency by staff unfamiliar with its location. The trust told us the signs were displayed at the nurses’ station.

The trust undertook bariatric (weight loss) surgery. We saw that there was appropriate theatre equipment and staff were trained in its use. We observed the safe positioning of a bariatric patient prior to their surgery. Theatre staff disposed of their waste appropriately in segregated bags. This practice was seen across other wards and departments, where labelled segregated bins were sited.

We looked at equipment on the wards and in theatre; the majority was clearly marked in date for servicing and were labelled with asset numbers to enable the clinical engineering team to track them. The trust used a software system to ensure that all equipment was serviced and safety checked. Clinical engineering incorporated new equipment into the system for servicing and maintenance. Clinical engineering was provided under a service level agreement with a neighbouring NHS hospital.

We saw that patient hoists were inspected on a six-month basis, safety checks were undertaken six monthly for medical devices and annually for other items. The equipment library was just installing a new system to track equipment by barcodes.
We were told of issues with the theatre equipment washers, there were entries on the risk register relating to them. We also saw patient complaints relating to cancelled operations relating to contaminated equipment. New washers installed were not working sufficiently well. The trust was undertaking microbial testing of the contaminated equipment.

Assessing and responding to patient risk

Staff completed and updated on line risk assessments for each patient.

The trust used an electronic monitoring tool for inputting patient observations on the wards, for example recordings of blood pressure, pulse, temperature and pain. The observations were then electronically assessed against an inbuilt warning score based on the National Early Warning Score (NEWS). Staff actions included escalating concerns to senior nursing or medical staff within set timescales if there were signs of deterioration. Staff used small handheld devices to input the details, trends and the full charts were accessed by logging into the system via a computer. We did not observe any larger tablets to show staff the patients’ status at a glance. Post inspection the trust confirmed that there were larger screen iPads available in the surgical wards. Theatres and recovery did not use the system but used a paper record covering the entire theatre stay.

The wards were supported with any deteriorating patients by an outreach team; this was a nurse led team of former critical care nurses who supported the wards across the full week, days and nights. They could access the electronic monitoring system remotely and assess the patients at risk, to ensure their attendance and support was targeted.

An internal audit report from September 2017 resulted in six recommendations relating to the processes around deteriorating patients, planned for completion by March 2018. Although there was felt to be room for improvement, no areas of significant concerns were raised.

Elective patients were pre assessed for various risks and their general fitness prior to their admission for surgery. For example their general anaesthetic risk, venous thromboembolism risk (blood clots or VTE), pressure ulcers, moving and handling. There did not appear to be a risk assessment for risk of potential falls or for any pre-operative confusion, which could affect the patients’ safety post operatively. The risk assessments were used as a baseline for their admission. The trust told us falls risk assessment are undertaken immediately pre operatively via Electronic Nurse Assessment and cognitive and mobility assessments are undertaken at the pre operative assessment stage.

Some of the pre-assessment clinics were held with the support of anaesthetists who held anaesthetic assessment clinics for patients who had been assessed as high risk. Staff could also discuss any queries relating to patients' abnormal blood results or physical tests, which were undertaken, based on national guidance.

Emergency and elective patient admissions were risk assessed for safety risks using an online tool. The assessments were only available on line, known as the electronic nursing assessments (ENA). These included the patients’ risk of falls and use of bedrails, risk of pressure ulcers, mobility risks, VTE and malnutrition. The system flagged reminders when reassessments were due. We saw that results of average compliance were displayed on notice boards in each ward along with other safety information. Staff told us that some patients were transferred to them without their initial assessments completed, which meant that their results were impacted negatively.

The compliance for VTE assessments between September 2017 and February 2018 was an average 98% for elective or planned surgery and 93.7% for emergency patients. Patients were
also fitted with anti-embolic socks and mechanical air foot pumps whilst on bed rest to prevent blood clots forming.

Although patient risk assessments were completed regularly, staff we spoke with told us there was no link made between them and the nursing documentation or care plans. Records, including the care plans we examined did not refer to the risk assessments at all. However, the trust told us that the ENA system along with the electronic observation system had helped reduce pressure ulcers by raising staff’s awareness of those at risk.

World Health Organisation (WHO) checklists were used to ensure compliance with the five steps to safer surgery. The trust used the specific WHO checklists for interventional radiology and for cataract (ophthalmic) surgery. The staff we spoke with told us the updated cataract WHO surgical checklist had started to be used the day before our inspection.

The compliance was recorded by speciality and by month. Each month we saw that most teams did not score 100%, very few teams consistently scored 100%. The compliance from February 2017 until January 2018 showed five teams who never scored 100% compliance. The remaining teams compliance varied between eleven months of 100% down to three months of 100% compliance.

The theatre team had developed a local safety standard for invasive procedures (LocSSIPS) in October 2017. The document detailed for example, standards for theatre staffing numbers, list scheduling, out of hours cover and handover information.

We saw that staff completed a monitoring tool for the safe use of venous cannulas; this was paper and was located within the patient’s record. Its aim was for the cannula to be removed as soon as it was no longer needed to reduce the risk of potential blood infections.

Patient falls were followed up by the use of a post falls checklist which included actions, recordings and a record of the fall. The patient’s record would have a yellow sticker inserted to flag a fall had occurred. An information sheet to inform which medicines may contribute to a fall was available for staff guidance.

**Nurse staffing**

The surgical care group worked hard to provide enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

All wards displayed on electronic wall screens at the entrance to the ward, this included their expected and actual numbers of registered and support staff for that day. This information was split into early, late and night shifts and was also available of the trust website for any interested public to access. The information displayed where staffing was at appropriate levels or where there were unfilled gaps.

Specialty senior nurses organised staff on a shift-by-shift basis to ensure that available staff were shared across the hospital to provide the safest cover for the wards. Some wards reported that staff disliked being moved, but they kept a record to ensure fairness and equity.

The trust told us that six monthly reviews of ward staffing levels took place to ensure that the staff establishment matched the acuity of the patients within the wards.

During December 2017, the trust reported staffing levels for surgery showed that during the day registered nurses shifts were filled between 73.9% and 99.8% and at night between 85.9% and
130.1%. The health care assistant day shifts were filled between 81.2% and 106.8%, and the night shifts between 96.6% and 134.6%. Where shifts were over 100% filled indicated that the trust was covering extra demand such as increased beds or patients with additional complex needs that needed a higher than normal nursing ratio.

The trust used an electronic rostering system to plan rotas; and produced most rotas with five to six weeks’ notice.

The trust reported their staffing numbers for Royal Bournemouth Hospital for the period April 2017 to November 2017 below.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Whole time equivalent staff</th>
<th>Number in post – November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Bournemouth Hospital</td>
<td>488.1</td>
<td>471.0</td>
</tr>
<tr>
<td>Total</td>
<td>488.1</td>
<td>471.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates
From December 2016 to November 2017, the trust reported a vacancy rate of 10% in surgery at Royal Bournemouth Hospital.

Staff we spoke with told us that there was active ongoing ‘rolling’ advertising and recruitment. One surgical ward sister was the lead for surgical recruitment, which staff felt, helped them to recruit suitable staff and to prioritise those in most need.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
From December 2016 to November 2017, the trust reported a turnover rate of 8% in surgery at Royal Bournemouth Hospital. This is better than the trust target of 10% or less.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From December 2016 to November 2017, the trust reported a sickness rate of 5% in surgery at Royal Bournemouth Hospital. This is worse than the trust target of 3% or less.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
The trust ran its own in house bank, which staff had to join in order to work any extra hours. If shifts failed to fill, staff were offered ‘golden shifts’ which attracted a financial bonus. Staff reported that some staff would always wait for the bonus to be available before booking the shift. Agency staff were sometimes authorised for unfilled shifts; initially using approved ‘framework’ companies who had approved standards for training and agreed shift rates. As a last resort when patient safety was compromised (known as ‘red flag’ shifts), high cost agency staff were authorised. Numbers of ‘red flag’ shifts were reported to the trust board.

From November 2016 to October 2017, the trust reported 92,035 total shifts in surgery at Royal Bournemouth Hospital. Of these shifts:

- 8,198 (8.9%) were filled by bank staff
Theatre staffing

Theatre shifts and allocations were based on the guidance from the Association of Peri operative Practice (AfPP), this meant that for each theatre list there was two scrub staff, two health care assistants and one operating department assistant. Theatre used the electronic rostering system to create the roster and a daily transfer made to an allocation spreadsheet, which was used to manage staff moves. A daily huddle took place at 4pm, which included a staffing review. Any cancellations of lists due to staffing numbers were reported, however no incidents have occurred for the past six months. Ongoing active recruitment was taking place to ensure that theatre staff were being recruited prior to staff leaving. This was one of a number of changes that were put in place to encourage and retain new staff. The theatre service had not used any agency staff in the past two years. Bank staff and other staff undertaking extra shifts adequately covered shifts. Staff told us this provided them with continuity of care. A decision to stop using agency staff in theatres had saved money and provided funds for an education team within theatres. The AfPP were including the hospital recruitment strategy as a ‘good news’ story in a future edition of their regular publication.

Medical staffing

The surgical care group at Royal Bournemouth Hospital had different cover arrangements for different specialties. The surgical specialties had a ‘hot’ consultant available between 8am and 8pm every day including weekends and then overnight on call, a registrar provided additional backup. Registrars with consultant anaesthetic support covered the orthopaedic service for post-operative elective patients out of hours. An on call orthopaedic consultant was also available out of hours.

The trust reported their medical staffing numbers below for the period April 2017 to November 2017 at Royal Bournemouth Hospital.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>WTE Staff</th>
<th>Number in post – November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Bournemouth Hospital</td>
<td>137.7</td>
<td>137</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>137.7</strong></td>
<td><strong>137</strong></td>
</tr>
</tbody>
</table>

Vacancy rates

From December 2016 to November 2017, the trust reported a vacancy rate of 4% in surgery at Royal Bournemouth Hospital. According to the most recent figures above this has fallen to 0.51%.

(Visited: 11/22/2017)
Turnover rates
From December 2016 to November 2017, the trust reported a turnover rate of 7% in surgery at Royal Bournemouth General Hospital. This is worse than the trust target of 1% or less. However, senior staff told us there always be turnover of junior medical staff within an acute hospital due to the nature of their training and rotations.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From December 2016 to November 2017, the trust reported a sickness rate of 2% in surgery at Royal Bournemouth General Hospital. This is better than the trust target of 3% or less.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
From November 2016 to October 2017, the trust reported requiring 2325 shifts of bank and locum medical staff at Royal Bournemouth Hospital:

- 983 shifts filled by bank staff
- 914 shifts filled by agency staff
- 431 shifts were not filled.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix
In October 2017, the proportion of consultant staff and junior staff reported to be working at the trust was about the same as the England average. The trust has fewer registrar group staff, but more middle career staff than the England average.

Staffing skill mix for the whole time equivalent staff working at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>18%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>22%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)
Records

Staff kept records of patients’ care and treatment either on line or in paper formats. There was no link from the on line patient safety risk assessments to the paper nursing records. Some previous records scanned into the electronic patient record were proving hard to access.

The trust had multiple electronic information systems, most of which did not fully interact with the other systems. Although most systems were trust wide and available to multiple clinical services.

The trust used a combination of paper and electronic medical records to care for patients. Discharged patients and previous patients’ records were scanned into an electronic record system (EPR). Staff told us the EPR system was not always easy to navigate and access specific previous records, as the scanning process did not always file notes appropriately. We saw evidence of this, escalated to the risk register. An entry related to the inability to access previous anaesthetic records, which was assessed and scored as a ‘moderate risk’.

Ward based patient safety risk assessments were electronically recorded in a standalone electronic system (ENA); nursing staff entered information on the patient’s admission using a tablet. Risks showed as red amber or green, depending on when they were due for updating. Other nursing and the current medical record were paper based. Most wards kept the medical records apart from the nursing admission records and care planning documents.

Medical records were mostly seen stored in open trolleys in named clip folders. Whilst in plain sight of the ward nursing station, we saw the stations were not always manned and could be accessed by the passing public. Nursing records including fluid charts, prescriptions, bowel charts and some care plans were found clipped to trolleys, on the outside of patient’s bays. Many were visible and could be accessible to the passing public. Very few were located at the end of the patients bed. We asked the trust if the records storage had been risk assessed, and were given a risk assessment undertaken after our inspection. The trust had identified various actions with completion dates.

We reviewed the various records and could see there was not a clear contemporaneous record. The nursing patients’ records were in a short stay booklet, a long stay booklet or within a multidisciplinary pathway format. Some nurses annotated in the main medical records. Within the booklets, there were pre-printed care plans for daily reviews but there were no clear documented references or links to the risk assessments undertaken on line. Staff we spoke with confirmed there was no current method to link them together, although all staff had access to both records. This meant that any new or temporary staff might not understand the specific care needs of patients from the records available.

All wards used a nursing handover sheet to refer to, most contained more details and updates of patient’s care than was recorded in the formal record. Staff we spoke with told us that the sheets were updated regularly throughout the shifts and were shredded for confidentiality at the end of shifts. There was no historical record saved therefore of any handover sheets. The trust told us that a handover sheet from every shift was retained on the surgical wards with the exception of Wards 12, 7 and Derwent Ward. The reasons for the non-retention of the records in these wards were unclear.

We found detailed therapy notes in the patient’s medical records or in the pathways, there was also daily medical reviews documented in most records we reviewed. Records of any consultant’s rounds were clearly marked as such.
Staff signed and dated entries in records; some had appropriate bleep or contact numbers for easier follow up by other staff. Some nursing records had a completed signature sheet at the start for easier recognition of staff signatures.

The trust had been moving to an electronic discharge summary with GPs practice systems for the past two years. The trust was in the process of rolling this system out. The surgical wards, however, used paper versions and spoke of ongoing difficulties getting outlying patients discharge summaries written before they were discharged. We were told that the trust had occasionally discharged some patients without any paperwork, which was a risk if the patient became unwell or if an updated medicines list was not provided. This meant there would be no information to guide other health professionals about what had happened to the patient whilst in hospital. However, on the days of the inspection all patients in the discharge lounge had their paperwork completed.

Theatres completed the theatre logs at every procedure; those that we reviewed on inspection were found completed fully.

**Medicines**

The service followed best practice when prescribing, giving and recording medicines. Storage of medicines was not always appropriate.

The trust stored medicines and intravenous fluids securely in locked wheeled trolleys, and secure cupboards. Controlled drugs (CDs) were stored in appropriate locked small cupboards with the keys held by the nurse in charge of the ward. The night staff checked CDs daily and we saw this was recorded. A random check of the CDs confirmed the accuracy of the checks. However, on some wards there were random and inappropriate items stored within the CD cupboards, this meant that already small cupboards could be further constricted.

Medicines storage cupboards and fridges were located in non-secure clinical rooms. Most surgical clinical rooms had no doors fitted; where there were doors, they were propped open with no means of securing them. The trust did not routinely monitor temperatures of the clinical rooms, although medicines can deteriorate if stored in temperatures above 25 °C. We did see some air conditioning units in some clinical rooms, but these were not in use. We saw that the medicines fridges were clean and checked regularly to ensure the temperatures were within range; and with one exception, all were locked.

The current CD administration record books were mostly locked within cupboards, some wards had numerous copies stacked which were not secure. In all the clinical rooms were two locked baskets for safe return and delivery of medicines.

Within some medicine administration trolleys, we saw there were large numbers of medicine blister strips stored outside of their boxes in a heap in the corner. There was a risk of strips ending up in the wrong boxes and it meant expiry dates and batch numbers could be difficult to monitor thoroughly. Also, if the medicine batch was recalled it would be impossible to check and locate all of the strips. We raised our concerns with the trust who undertook reviews of medicines trolleys after our inspection across all the wards. The trust had identified that the issues were in two surgical wards. At the unannounced inspection, we noted that there were no loose medicines in the trolleys and all staff we spoke with were aware of this issue and ensuing actions.

We reviewed 16 prescription charts for completeness and to ensure that missed doses were appropriately coded, overall they were completed well. We saw that patients’ allergies were noted and the type of reaction described. However, we saw that eight (50%) of the charts we looked at did not detail the patients’ weights, despite the patients being within the surgical specialisms.
There was a potential need for anaesthesia, pain relief and weight adjusted thrombo prophylaxis (to prevent blood clots), which would require an accurate weight.

Trust data relating to 5334 prescription charts surveyed between December 2016 until November 2017 showed that 99.6% patients had their allergy status completed and of them 93.9% had a red ‘alert’ arm band applied. Of the omitted doses, 32.5% had a valid clinical reason documented 4.9% either had a question mark or were left blank, 56.9% were refused by the patient and 12.6% medicines were not available.

The pharmacists regularly reviewed the charts; we saw notes attached to charts for doctors’ attention when they were available. The location of the charts seemed to vary on different wards, some were on patients’ bed ends but others kept on trolleys which could be a potential risk of patient identification error.

We observed some patients being helped and administered with their medicines; staff appropriately checked their identity bands. They asked for identification against the chart details and the patient’s armband to ensure the patient was correctly identified.

The trust told us that they were moving to an electronic prescribing and administration system (EPMA), this was a joint project with a neighbouring NHS trust and was planned to be rolled out later in the year.

Medicines for patient to take away (TTAs) were available from the hospital pharmacy seven days a week, out of hours staff could gain help and guidance from an on call pharmacist.

**Incidents**

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

However, some recent Never Events showed that learning was not embedded following previous Never Events.

The trust used an electronic system for reporting adverse incidents, the system provided a trail of actions and escalated to senior staff if there was a serious incident (SI) causing patient harm.

The surgical specialities reported 1393 incidents between November 2016 and October 2017, 1369 (98.3%) incidents were no harm or low harm. 21, (1.5%) incidents resulted in moderate or severe harm with three incidents (0.2%) resulting in death.

Patient accidents were the most reported incident within the same period, which were 20.8% of all incidents. 1,039 (75%) of incidents were reported within 14 days of the incident occurring, however, 67(75%) of incidents were reported over 90 days afterwards. The trust had developed strategies and the trust reported that since November 2017 all incidents were reported within 30 days.

The hospital carried out their investigation based on the National Patient Safety Agency (NPSA) Root Cause Analysis Tool Kit. The report included evidence of discussion with the patient’s family members throughout the patient’s treatment. The investigation team had identified learning points and set out an action plan to mitigate the risk of this type of incident happening again.
Serious incidents were raised with the risk committee, and discussed at local governance meetings. Actions were shared with staff / newsletter and staff meetings and huddles. Wards and departments shared their monthly incidents between their teams and also at a monthly risk and governance meeting across the specialty. This ensured that any learning was shared.

An incident report was reviewed relating to a recent potential fire within the theatre. The incident was graded as a ‘near miss’, we saw from the report that education was planned as result of learning being identified.

**Never Events**

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

Since May 2017, the trust has reported five incidents classified as never events for surgery. Four were wrong site surgery, and one a retained foreign object. All never events were surgical procedures meeting serious incident criteria:

- Dermatology; wrong skin lesion was removed from patient’s back.
- Interventional radiology; due to positioning the patient’s wrong side was accessed initially despite checks being done.
- Dermatology; a biopsy was taken of the incorrect lesion on nose.
- Urology; following a procedure, part of a guide wire was found inside the bladder.
- Ophthalmology; wrong eye prepared for cataract surgery

(Source: Strategic Executive Information System (STEIS))

Since these events took place, the trust medical director is leading focussed actions. We saw copies of the report including a senior review and learning recommendations.

There was a further never event that had occurred within another speciality relating to the misplacement of a nasogastric feeding tube. The implications following the never event were trust wide. However, we are aware the incident had occurred after a NHS patient safety alert was issued in relation to this risk in July 2016 for trust actions by April 2017.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in surgery, which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, there were two types of incident reported.

- A surgical or invasive procedure incident, which met SI criteria; there were three incidents (75% of total incidents).
- A patient slip, trip or fall meeting SI criteria; there was one incident (25% of total incidents).
The surgical services used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

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

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

Data from the Patient Safety Thermometer showed that the trust reported 18 new pressure ulcers, three falls with harm and two new catheter urinary tract infections (CUTI) between December 2016 and December 2017 for surgery.

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

(Source: Strategic Executive Information System (STEIS))
The prevalence rate of pressure ulcers at the trust each month fluctuates between zero cases, as seen in March-April 2017 and almost three cases as seen in January 2017.

Three falls were recorded between December 2016 and December 2017. Two were recorded in May and one was recorded in July 2017.

Two catheter urinary tract infections were recorded during the reporting period, with one occurring in September and the other in October 2017.

(Source: NHS Digital)

Information relating to the safety thermometer data was displayed on individual wards for the information of both staff and patients and visiting relatives.

Is the service effective?

Evidence-based care and treatment

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

The surgical care group mostly managed services in line with guidance based on evidence and best practice from the National Institute for Health and Care Excellence (NICE). Plus, the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI), and the National Confidential Enquiry in Patient Outcomes and Death (NCEPOD).

Some elective surgical care such as joint replacement surgery was based upon the enhanced recovery pathway, which used best practice recommendations to streamline and shorten the patients’ stay in hospital.

Surgical and services participated in many national audits for example, the National Emergency Laparotomy Audit (NELA) and the Oesophago-Gastric Cancer National Audit (OGCNA).

Bloods and investigations that were undertaken pre operatively to assess the patient’s fitness for surgery were based on NICE guidance. Nurse practitioners gave out information relating to surgery, pre-operative fasting times, types of anaesthesia and pain relief both verbally and in a paper format. However, we saw some discrepancies in the advice given within the hip replacement booklet and in the orthopaedic non-steroidal anti-inflammatory medicines and aspirin advice. One advised stopping certain medicines one day before surgery, the other seven days before surgery; this differing advice could cause anxieties in pre-operative patients. We raised this with the preoperative assessment nurse.

Patients were assessed for their risk of venous thrombo-embolism pre-operatively; those at risk were offered appropriate prophylaxis pre and post operatively in accordance with NICE guidance.

Clinical educators in the wards and in theatres kept up to date with national directives specific to their areas of practice and shared the details with other staff.

The pain pathways that were used in orthopaedics had been designed and dated as 2011 and 2012. They did not appear to have been reviewed since then to ensure that newer techniques or medicines were not more suitable. There were no version numbers or review dates indicated, although there were author’s names at the bottom.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

However, fluid charts were not consistently totalled to give an accurate 24-hour balance. Food charts were not always completed.

The surgical wards practiced protected meal times; this meant that visiting was restricted whilst meals were underway. Most staff we spoke with told us of a flexible approach when patients needed encouragement as they were happy for visitors to sit and eat with or to help to feed patients. Most wards had ward hostess roles who helped patients choose food and gave their meals out, they also offered hand wipes prior to meals. For patients who required assistance with their meals we were told that red trays and jugs were available, although we did not see any in use.

There were volunteers known as ‘mealtime companions’ for those patients who needed additional assistance with meals. However, when these were not available we saw patients waiting for help with meals. Staff we spoke with told us that food was available outside of meal times, although not hot, some sort of food could be obtained for post-operative or newly admitted patients. Some wards told us that they routinely ordered extra sandwiches for new patients.

The wards used fluid balance charts and food charts to record the patients’ intake and output, there were variations seen in their completion. The fluid balance charts were not consistently completed and many were not totalled every 24 hours to provide an accurate balance. We found food charts were also inconsistently completed.

Staff were able to refer patients with specific nutritional needs to the dietitians, for advice and support. The patient’s nutritional risk status was assessed using the Malnutrition Universal Screening Tool (MUST) to decide whether a referral was required.

We saw many patients receiving nutritional supplements to ensure that they received adequate nutrition and hydration. Food such as Kosha and Halal meals were also available on request. For patients without normal oral routes for food, food was provided via a different method such as tube or parental feeds.

Anti-sickness medicine was provided routinely for postoperative surgical patients. There was a gradual re-introduction of normal feeding and hydration following surgery.

Pain relief

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

The trust employed an acute pain team; we saw many patients’ records contained detailed assessment notes and recommendations for patients’ care. Staff told us they were a good resource and we saw evidence of their input on most wards. Some of the team were nurse prescribers so that they were able to ensure pain relief was prescribed promptly.

There were specific pain relief pathways written for some cases, we saw the hip and knee surgery and the shoulder replacement pain pathways. Preoperative pain psychology was used for hip and knee replacement patients as a pilot during 2016 and was now fully adopted.
Patient controlled analgesia (PCA) was available for patients; ward staff told us that the pain team saw all patients with PCAs routinely to follow them through. Epidural pain relief (via the spine) and nerve route ‘blocks’ for specific surgical cases was also available.

Nurses recorded their patients’ pain scores via the electronic system when other observations were recorded. The score combined with other observation scores to identify if the patient was stable, improving or deteriorating.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

**Relative risk of readmission**

**Trust level elective readmissions**

From September 2016 to August 2017, overall patients at the trust had a lower than expected rate of readmission for elective admissions when compared to the England average.

Urology patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

Both ophthalmology and elective orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

**Elective readmissions – Trust Level**

![](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

**Trust level non-elective readmissions**

From September 2016 to August 2017, all patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Patients in general surgery, urology and vascular surgery at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective readmissions – Trust Level**

![](image)
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity  
(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 52.2% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the 69% national aggregate. This had improved from the 2015 figure, which was 54%.

The risk-adjusted 90-day post-operative mortality rate was 0% which was better than the 3.8% national aggregate. This was an improvement on 2015 figure which was 1.5%.

The risk-adjusted 2-year post-operative mortality rate was 14.9% which was as expected compared to the national aggregate. The 2015 figure was 16.7%.

The risk-adjusted 30-day unplanned readmission rate was 13.5% which was as expected compared to the national aggregate. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 43.6% which was as expected compared to the national aggregate. The 2015 figure was 33.8%.

(Source: National Bowel Cancer Audit)

**National Vascular Registry**

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 2.3% for Abdominal Aortic Aneurysms, indicating that the trust was within expected range. The 2016 figure was 1%.

Within Carotid Endarterectomy, the median time from symptom to surgery was nine days, which was better than the national standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 0%, which was within expected range. The 2016 figure was 0.8%.

(Source: National Vascular Registry)

**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 17.8%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The
audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 17.8%.

The 90-day post-operative mortality rate was 4.1%, which was as expected. The 2015 rate was 3.8%.

The proportion of patients treated with curative intent in the strategic clinical network was 40.1%, which was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

In the 2016 National Emergency Laparotomy Audit (NELA), Royal Bournemouth Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 171 cases.

Royal Bournemouth Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 137 cases.

Royal Bournemouth Hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 81 cases.

Royal Bournemouth Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 44 cases.

The risk-adjusted 30-day mortality for the Royal Bournemouth Hospital was within expectations, based on 171 cases.

(Source: National Emergency Laparotomy Audit)

Recent data provided by the trust illustrated the last three quarters of reporting, between 1 March 2017 and 30 November 2017, NELA makes these available for trusts to track their performance. From the latest figures, the trust consistently shows ‘red’ as not achieving the post-operative assessment of patients over 70 years by older persons’ specialist. In 2016, the trust achieved 36%; the 2017 reports illustrate a reduction in compliance to 3.3%, 0%, and 3.7% for each quarterly report. The trust has told us this had been noted and from February 2018 action was taken with the provision of dedicated medical and nursing input for older people on surgical wards.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the
right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on:

- Groin hernias was better than the England average.
- Hip replacements was better than the England average.
- Knee replacements was better than the England average.

(Source: NHS Digital)

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance to provide support and monitor the effectiveness of the service.

On inspection, we saw patients being cared for by a variety of staff members, including volunteers; patients told us that in general they regarded the staff’s skills and abilities with confidence.

The trust spoke of the aim for ‘continuous improvement’ and gave examples of staff attending leadership development, customer care workshops, and two days of quality improvement training. They used a colour coded ‘Brain’ to indicate when staff were in date with their essential training, a slogan of ‘keeping your brain green’ had been adopted. Staff of different disciplines we spoke to were aware of the initiative and their own status.

The trust had developed SEPSIS and deteriorating patient training; data showed that a total of 174 staff had attended the training which included over 80 registered nurses and midwives. The trust was just about to launch a new e learning for SEPSIS at the end of March 2018, this was to form part of essential training skills for all staff.

Theatres had developed a programme of staff support and engagement; there had been an investment in practice educators over the past two years. Different workbooks were designed to support staff gaining their competencies with protected time for training every month. The training included simulation sessions, which all staff were expected to attend at least one per year, these covered for example intubation and major haemorrhage. Theatre staff were not permitted to work in theatres which used lasers, unless they had completed relevant training.

New staff had to be signed off as competent by the education team, before being able to fully undertake their roles and responsibilities. Some wards and departments used the monthly team brief session to provide updates and any learning for their teams.
The trust has invested and implemented in a bespoke security support worker role, whereby individuals are trained in the care of patients who are restless and agitated. The training package for the role was run in house.

**Appraisal rates**

The trust had adopted a ‘values based’ appraisal system stating that 90% of trust staff had received an appraisal in this format.

From December 2016 to November 2017, 87% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal</th>
<th>Staff requiring an appraisal</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>239</td>
<td>266</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>52</td>
<td>58</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>287</td>
<td>323</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>79</td>
<td>91</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>13</td>
<td>35</td>
<td>37%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff told us that the trust used their annual appraisal to identify their training needs and agree their personal development plans. Without full compliance of their mandatory essential training staff were not encouraged to apply for additional education or development.

Senior medical staff were encouraged to have appraisal training so they could undertake appraisals for junior colleagues, currently 20% had had this training.

**Multidisciplinary working**

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

We saw many examples of multidisciplinary teams working together to support patients on inspection. These included, for example, doctors, nurses and therapy staff, administration, housekeeping and domestic staff. Staff could also access specialist staff to support their patients if required, such as dietitians, acute pain specialist nurses and other medical speciality teams. On
some specific wards, such as elective orthopaedics, therapists were ward based with their own exercise rooms or facilities.

Most wards and department produced updated handover sheets, which held important information about the patient’s progress and recovery. A shift handover also took place regularly for all ward and support staff. Regular formal clinical ward rounds were used daily to review the patient’s progress against their plans. White boards were used discreetly to provide ‘at a glance’ information relating to patients name and consultant; we saw no inappropriate information on display.

The patients’ records held a standard transfer sheet, which was used when the patient was moved from one ward to another; these varied in the details inputted but were intended to give the receiving ward sufficient information about the patient’ plan of care, the consultant overseeing the care and the plan for discharge.

Clinical nurse specialist roles were in most surgical specialities to support patient pathways, for example pre-operative assessment and acute pain. The trust was developing a new clinical nurse specialist role to support older people. Most wards and departments had resource folders with the contact details of specialist support; some were listed on notice boards at the nurses station.

**Seven-day services**

The trust provided an on call facility over 24 hours for seven days per week if the consultant was not physically on site. Surgical specialities had a variety of on call arrangements by consultants and middle grades covering the seven days. Some senior cover was shared with a neighbouring NHS hospital trust, for example, emergency gynaecology transferred to the other NHS trust after 5pm on Friday and therefore was covered by the other NHS trust. The neighbouring NHS trust was only a short journey from Bournemouth Hospital. Surgical consultants undertook daily ward rounds including weekends.

Orthopaedic surgery taking place at Royal Bournemouth Hospital were planned surgical cases, therefore senior consultant cover was on site was Monday to Friday. However, consultant emergency cover was provided by the neighbouring NHS trust, although junior doctors covered every day on site. Additional support included weekend junior ward rounds. There was a middle grade doctor available all day, although they also undertook other clinical activities in either clinics or theatres.

The hospital at night team that consisted of junior medical staff and senior nurses, provided clinical cover of the hospital out of hours. The critical care outreach team was also available seven days a week 24 hours a day to access and provide support for deteriorating patients on the surgical and orthopaedic wards. An emergency theatre and team were available at any time seven days per week if emergency theatre support was required.

Diagnostics were consultant supported eight until ten pm seven days per week, out of hours covered with remote reporting and on call back up. X-Rays plus interventional radiology, CT and MRI scans were available for seven days per week and 24 hours a day. Ultrasound was available until six pm daily, with four and a half hours Saturdays and Sundays. Pharmacy was available seven days per week with an on call pharmacist to support out of hours.

**Health promotion**
On inspection, we saw numerous advice and information leaflets available to patients and relatives, these included help with preventing pressure ulcers or preventing falls. Elective or planned surgical patients were given information relating to their surgery, anaesthetic and post-operative health, for example preventing blood clots.

There were large pictorial displays of patient advice set up in the trust when we visited, these covered topics such as avoiding the flu and norovirus. The trust had an initiative running to ‘prevent pyjama paralysis’ this aimed to encourage patients to mobilise and prevent complications arising from immobility. The trust website detailed ‘understanding health’ talks that were scheduled for the public to attend for health information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Patient records were reviewed for the completion of the appropriate consent forms, we saw that the majority of patients had completed and signed consent forms within their records. For those patients who lacked capacity, a different appropriate consent form was used, and signed by two senior clinicians.

Staff we spoke with told us that they were aware of the Deprivation of Liberty (DoLS) process and the link to the mental capacity act. They told us of trust leads which they could access for advice. We saw in some records the fully completed applications for DoLS with reference to the patient’s mental capacity.

Elective orthopaedic patients who had joint replacement surgery had consent taken so that their details could be inputted into the National Joint Registry. We saw these completed and held within the patient records.

Some patients had ‘allow a natural death’ forms fully completed in their medical records, which was a signed document opting out of interventions to prolong their life.

Is the service caring?

Compassionate care

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

The trust had developed a ‘dignity pledge’ and had a trust wide event ongoing named ‘end pj paralysis’ this initiative was aimed at promoting mobility and dignity and therefore avoiding associated complications.

Patients were issued with disposable clothing for wearing to theatre for their procedures, for example, dignity gowns, shorts and pants. Ward patients had appropriate clothing and gowns to preserve their dignity. The ward privacy curtains had clear signs to indicate when they were closed to maintain patient’s privacy and dignity.

Patients being transferred to the Derwent Unit from the main hospital had a convoluted journey through the pathology clinic waiting areas. The trust told us that two staff always accompanied
patients to ensure that they were covered appropriately with blankets. As part of the inspection, we received 39 patients’ comment cards from the Derwent Unit; almost all of them spoke of the excellent care they had received.

Patients told us that staff ‘went beyond what was asked of them’ and all spoke of the kindness of the staff looking after them.

**Friends and Family test performance**

The trust told us that the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Friends and Family data inpatient wards were ranked 2nd out of 172 Trusts in January 2018. They had a response rate of 18.9% which is above the national average of 15%. The average response rates varied between 18% and 47% for each ward or department. The percentage recommendation for the hospital as a place of treatment was between 92% and 100%.

(Source: NHS England Friends and Family Test)

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

Patients having planned surgery pre-operative assessments were given opportunities to ask questions to reassure them of what was going to happen. Patients were also given information leaflets with help numbers for their use.

Patient we spoke with gave us examples of how staff had supported them during their inpatient stay. Many gave positive statements about the staff that were caring for them, ‘all excellent...’ ‘they do everything for you... try to keep you as comfortable as possible.’ ‘The staff are lovely.. dedicated, go beyond what is asked of them.’ ‘A patient who became disturbed had a member of staff sit with him to reassure him...’

Most wards offered patients earplugs and eye masks to help them sleep in hospital, recognising that sleep deprivation was distressing to most patients.

We observed many staff interactions with patients, which were seen to be respectful and compassionate. Patients who had recent life changing surgery due to cancer spoke of the support the staff had given them, both on the ward and from the clinical nurse specialists.

One patient with a learning disability gave us feedback on how medicines were given to them inappropriately, this was fed back immediately to the ward sister. The patient felt that the nurse had not appreciated how he wanted his medicines given to him.

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

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

Many patient information leaflets were available on wards and in departments; all were available in larger font. The trust website had ‘easy read leaflets’ that were available for staff to download for patients who needed them or they could be accessed by patients themselves.

Patients comments included, ‘My journey started on 25 January- I have been informed every step of the way, not only verbally but also with literature.’ ‘All the staff have introduced themselves and showed real interest. I have consistently been treated with respect’.

The patients we spoke with told us that although they were given information they were not actively involved in their care planning. The patients having joint replacement surgery had detailed
plans of their pathway and the expectations post operatively. There was an educational ‘joint school’ prior to joint replacement surgery, which enabled the patient and their relative to ask any questions.

Most wards had information for relatives and visitors on notice boards at the ward entrances, aimed to help understand the ward and its routines. For example the ward’s visiting and meal times, staff names and roles. Some had photo boards for easier staff recognition.

One ward’s senior staff told us they were trialling an ‘open clinic’ during visiting time, so relatives or visitors with queries or concerns could access help in a more timely way. This was only in its initial stages.

Discharge planning information was widely available; we saw many patients had information leaflets available on their bedside tables. The leaflets were designed for individualisation with ward name, ward sister and proposed date of discharge spaces available. There was no space however, for the patient’s name who the information related to, which might cause some anxiety to the patient.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**The trust planned and provided services in a way that met the needs of local people**

The trust had a shared arrangement of orthopaedic service with a neighbouring NHS trust. The Royal Bournemouth Hospital did not provide any emergency (trauma) orthopaedic surgery; it only performed elective or planned surgery. The trauma orthopaedic surgery took place within the other NHS trust as it was a trauma centre. Consultants who operated on both trauma and planned cases worked across both sites, some consultants operated on planned cases only and only worked at Bournemouth. The anaesthetic service also rotated across both sites.

The trust had a standard operating procedure for the swift transfer of any trauma patients, as delay in operations for some cases such as hip fractures would affect their long-term outcomes. Most ambulances did not bring trauma cases to the hospital but went straight to the trauma centre. The trust told us that very few patients needed to be transferred. From March 2017 until February 2018, 37 patients with hip fractures were transferred to the other trust. Staff we spoke with told us that even inpatients falling and sustaining a fracture were transferred. This transfer could cause distress and confusion within the elderly cohort of patients.

The trust had been part of the Dorset wide clinical service review, and it had been recently agreed that all trauma to be transferred to Bournemouth and the elective services to the neighbouring trust. There was ongoing planning around time scales for these moves.

**Average length of stay**

**Trust Level – elective patients**

From October 2016 to September 2017, the average length of stay for all elective patients at the trust was 2.8 days, which was better compared to the England average of 3.3 days.

- For orthopaedic elective patients at the trust was 3.7 days, which was higher compared to the England average of 3.3 days.
- For urology elective patients at the trust was 1.7 days, which was lower compared to the
England average of 2.0 days.
- For ophthalmology elective patients at the trust was 1.2 days, which was lower compared to the England average of 1.4 days.

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2.8</td>
<td>3.7</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Urology</td>
<td>1.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1.2</td>
<td>1.4</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

**Trust Level – non-elective patients**

The average length of stay for all non-elective patients at the trust was 3.8 days, which was lower compared to the England average of 5.0 days.

The average length of stay for general surgery non-elective patients at the trust was 3.9 days, which was equal to the England average of 3.9 days.

The average length of stay for urology non-elective patients at the trust was 2.3 days, which was lower compared to the England average of 2.9 days.

The average length of stay for vascular surgery non-elective patients at the trust was 7.4 days, which was lower compared to the England average of 11.0 days.

The trust did not perform any emergency trauma surgery at the Royal Bournemouth Hospital.

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

The service took account of patients’ individual needs.

The trust had taken part in the National Audit of Dementia Care in General Hospitals 2016-2017, the hospital scored between 68% and 100% for five themes. The scores were higher than the national average in each theme except for two which the trust scored zero. The trust was ranked first nationally for governance relating to dementia. The trust had a local dementia action plan for the same time, which included for example the development of dementia champions, and information packs for carers. Most of the actions were completed in July 2017.

We saw patients with cognition problems had ‘this is me’ documents in their notes to help staff care for the patient by understanding their previous history. However, there were no obvious visual signals for staff without access to records such as domestic staff, in identifying and understanding the patient’s cognition issues. The trust told us that they used ‘forget me not’ signs on the boards over patients’ beds.

The trust had told us post inspection that in late 2017 the Care Group has implemented a surgical nurse practitioner focusing on the specific needs and care of older people undergoing surgery.
Some wards used pictorial magnets to provide visual information without compromising patients’ confidentiality on the white boards. However, we did not see any specific flags for patients who may be living with dementia or those with learning difficulties to assist staff in caring for them. Most wards told us they had staff champions for issues like dementia or though it was not obvious who they were.

Patients who were living with dementia were identified on admission via the admission process, the electronic nursing assessment provided a prompt for all emergency patients over 75 years to be screened using set questions. The trust had since told us that patients’ cognitive assessments were carried at the pre-assessments stage. The trust had a dementia and delirium team who could support wards in managing patients living with dementia, and monitored the screening for completion. Care planning was discussed and agreed with the patients’ significant others to ensure their complex needs were considered. Post inspection the trust has told us ‘This is me’ diary accompanied the patient to theatre. There was also a flag on the theatre schedule list which alerted staff of the patient’s additional needs.

The trust had a mechanism for flagging patients with learning disabilities on patients’ records; the trust had employed a lead nurse to support the patients with close links to the mental health liaison team. Pre-operative assessment nurses flagged patients with learning disabilities prior to their booked admissions so that ward staff and accommodation were prepared.

The trust told us that reasonable adjustments could be made to accommodate patients with complex needs; these could include pre-admission visits to area, specialist equipment such as cutlery or hearing devices and supporting carers to stay with patients. There were specific documents of the trust website which had pictures and a large font with spaces for reminders aimed at patients living with dementia or a learning disability.

The trust had multiple sources for interpreters if required including face-to-face and British sign language. Interpreters were booked via the patient’s advice and liaison service; although staff were aware of them, they told us they were not needed very often.

Patients with specific cultural or religious needs were able to access alternatives to blood transfusions, prior to their planned surgery. Some local faith groups had provided the facilities for the local trusts so this would be available.

The Chaplaincy consisted of a team of trained hospital chaplains from different faiths, which included Christianity (including Roman Catholic) Muslim, Hindu and Jews. If a patient required a chaplain of a different faith, staff were able to access this. The Chaplaincy team provided a 24-hour emergency call out service and they held a register of other faith leaders who could attend in an emergency as required. Patients wanting to be visited could refer themselves or be referred by staff or visitors.

**Access and flow**

Most people could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with good practice. Orthopaedics were not meeting the 18 week referral to treatment target.

The trust admitted emergency patients routinely to assessment units and then moved them to an appropriate ward following investigations. Between December 2016 and November 2017 there were 737 patients moved between 10pm and 8am from the surgical admission unit. During the same period there were 266 patients moved from other surgical wards in the same time scale. To prevent confusion within elderly patients’ other ward moves for capacity issues are ideally planned during daytime hours.
Referral to treatment (percentage within 18 weeks) - admitted performance

From December 2016 to November 2017, the trust’s referral to treatment time (RTT) for admitted pathways for surgery has remained in line with the England average. In the latest period, November 2017 65% of this group of patients were treated within 18 weeks versus the England average of 69%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, two specialties were above the England average and one specialty was below the England average. Two specialties had a 0% result because they do not take place in the trust.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>78.5%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>75.6%</td>
<td>72.8%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>48.2%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.0%</td>
<td>70.5%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0.0%</td>
<td>83.2%</td>
</tr>
</tbody>
</table>

We saw that between July 2017 and February 2018, RTT had not been achieved for the recommended 92% of patients but had been between 89.68% and 84.56%. However, this performance was better than the national average.

The trust was operating extra lists on Saturdays to try to reduce the waiting times in orthopaedics.

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.
Over the two years, the percentage of cancelled operations at the trust showed an upward trend but was generally lower than the England average. In Q2 2017/18, the trust cancelled 80 surgeries. Of these 4% were not treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust**

Over the two years, the percentage of cancelled operations as a percentage of elective admission at the trust showed a stable trend, and was routinely lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Cancelled Operations as a percentage of elective admissions - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust**

(Source: NHS England)

Patients due for surgery were phoned three days before their surgery to check for fitness, this helped to reduce last minute cancellations. The theatre team had a robust procedure prior to patients being cancelled to ensure escalation, and patients were kept tracked. The trust reported on the day cancellations every week, which was reviewed at the trust's performance management group meeting. Any patients who were not able to be rebooked within 28 days were reported to the trust board in the monthly performance report.
The trust discharge team collected numbers of patients who were medically fit for discharge, which included delayed transfers of care. Between December 2016 and November 2017, 680 surgical patients were recorded as medically fit for discharge. Delays could be caused by a lack of beds in care homes or a lack of community staff to support the patient at home.

Patients we spoke with felt fully informed of any delays relating to their care pathway ‘I’m kept up to date by all the staff…” if there is something they are not doing they let you know why..

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

**Summary of complaints**

The wards displayed information about how to raise a concern or complaint, patients were also offered information leaflets with the details of how to do this using the patient advice and liaison service based in the hospital.

Between March 2017 and February 2018, the surgical care group received 118 complaints, however they had received over 1400 compliments in the same period. The highest themes were communication with 28 complaints and patients’ care with 25 complaints.

The surgical care group achieved 81% of first responses to complaints with 25 working days. Four months out of twelve, they had achieved 100% within the time scales, the lowest month compliance at 33%. The trust was looking to introduce variable target timescales in recognition that some complaints were inherently more complex, and would take longer to respond to that others.

The surgical care group discussed learning and outcomes from complaints at the risk and governance meeting, which took place quarterly.

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**Is the service well-led?**

**Leadership**

**Managers within the service had the right skills and abilities to run a service providing high-quality sustainable care.**

The senior executive team was visible and staff recognised them from walkabouts in the trust and being engaged in staff events. They had previously pledged to be the ‘most improved trust’ by 2017 following previous CQC inspections.

A team of three, a director of operations, head of nursing and quality and a medical lead led the surgical care group. Each directorate (anaesthetics, orthopaedics and surgery) had a similar lead team, with matrons for each speciality. The senior clinical leaders in the trust including matrons wore distinctive red uniforms to identify them to staff and public. Most wards clearly identified their matrons and ward leaders on photo boards at the entrance to the ward.

The trust had formulated a ‘people plan’ in 2017, which identified the staff planning priorities until 2020. There were eight priority themes, which included leadership and management; the trust had recently introduced a new leadership strategy and model. The trust had previously canvased the staff views and found staff in leadership and management roles had identified issues in support
and a lack of clarity over the trust expectations. The trust had since delivered bespoke leadership training for the care group leaders and a matron’s development programme.

The trust held an annual leadership summit for 200 staff and had trained and implemented team coaches to support the development of effective teams. Staff we spoke with knew the care group leaders and spoke of them being visible and accessible. When we inspected we saw that matrons supported staff in most areas. However, on one ward some staff spoke of feeling unsupported due to the absence of the ward manager.

Vision and strategy

The service had a vision based on the trust values for what it wanted to achieve and workable plans to turn it into action, developed with involvement from staff, patients, and key groups representing the local community.

The trust had developed a strategy for joint working with local partners following the clinical service review to prepare for merging with the neighbouring trust. The trust vision was to ‘work in partnership and continually improve services’ which was underpinned by four local objectives.

The surgical care group ‘A’ had used a recent away day to decide it’s vision. This was: ‘A’ Team: Trusting our staff to deliver the right care for our patients’. (March 2018)

The surgical care group used the four trust objectives, valuing staff, improving quality and reducing harm, strengthening team working and listening to patients for specific surgical objectives and actions. The identified actions were to help achieve the objectives.

The service was progressing the vision to merge with its neighbouring trust. One surgical quality improvement project was improving the flow of surgical patients through theatres and into appropriate beds. There was potential to improve theatre utilisation, from 74% to 85% in advance of the proposed move to become the trauma centre in 2019. The senior surgical team felt that they were in a ‘good’ position to merge with the neighbouring NHS trust due to many shared working arrangements, for example, anaesthetic and orthopaedic rotational teams.

Culture

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

The trust spoke about ‘a culture of continuous improvement’, involving clinically led improvement projects and staff engagement. They had identified four key values, pride, communicate, improve and team work. The trust had engaged in a cultural audit and 25 staff to be ‘change champions’ from across different grades and departments, to agree the trust values.

Within the surgical care group’s ‘valuing staff’ objective, there were ten action points detailing how the care group was going to achieve the objective. These included for example, ensuring staff had time and places for their breaks and ensuring staff had meaningful values based appraisals.

This trust overall was the highest performing acute trust in the NHS staff survey results in 2017.

The most recent NHS staff survey (2017) indicated improved staff satisfaction with increased scores for 22 questions. The local ‘staff impressions survey’ had improved in the ‘overall impression of mainly good’ score up to 94%.
There were various support networks for staff; these included for example, the wellbeing link group, the book club, weight management, alcohol management and pause for thought. There were other fitness type clubs to support staff to keep active.

Staff we spoke with told us they were proud to work in the trust, which had a person centred culture.

**Governance**

**Service leaders used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**

The care group had regular risk and governance meetings in each of the specialities, we saw the minutes from various meetings that had taken place, for example orthopaedics, surgery and theatres. They varied from monthly, bimonthly or quarterly and attendance was recorded. Each meeting covered standing agenda items such as incidents, serious incidents, risks, infection control and complaints. The previous meetings actions were reviewed, and progress documented formally. These meetings fed into the quarterly care group governance meeting and were also attended by the head of nursing and quality who chaired the care group meeting. The agenda showed the same standing agenda items and which meant that issues and learning was shared across specialties.

Any potential new surgical techniques or equipment had to follow a strict process, a proposal had to be made with evidence and be signed off by senior clinicians before the procedure was to be undertaken.

The trust had a ‘learning from deaths’ policy including a structured template which specialties used to base their reviews of patient’s deaths upon. The template was electronic and used to input details to discuss patient case studies at speciality mortality and morbidity meetings. Any actions or learning points were identified; which were fed into the trust monthly mortality surveillance group. The trust produced a bimonthly mortality newsletter; this included any learning from mortality reviews for sharing across the trust.

**Management of risk, issues and performance**

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

The surgical care group’s risk register had 35 open risks. The surgical teams had assessed and scored seven of the risks as moderate, having a score of between eight and ten. There were three risks assessed and scored as very low, with a score between one and three. The remaining risks were low, scored between four and six. The register was colour rated with red, amber, yellow and green denoting levels of risks.

We saw from the minutes of the specialty and care group governance and risk meetings that the risk register was routinely discussed, with emerging risks being reviewed and considered for escalation to the register.

The highest risks included, for example, the poor state of the sterile supply and distribution service building, the aging washers, which were becoming impossible to repair. Other moderate clinical risks related to access to previous anaesthetic records, and surgical staffing establishment.
The trust board monitored the surgical care group's performance via a dashboard specific to the care group. The dashboard included quality indicators such as patient feedback, complaints and mixed sex breaches. There was infection control data relating to blood infections, MRSA and C. Diff. Compliance with risk assessments such as patients risk of blood clots (VTE) and any serious incidents. The surgical dashboard also monitored operational performance, which included for example, compliance with access targets in cancer and 18 week refer to treatment targets (RTT).

The surgical performance and forecasts against the priority operational targets were incorporated into the monthly operational performance report. The chief operating officer compiled a report which was shared with the trust board.

Information management

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

The trust utilised key metrics to illustrate their improving performance to staff and patients, these included the hospital standardised mortality ratio and the RTT performance against the national average. The metrics also displayed a downward trend in serious incidents including patient falls and hospital acquired pressure ulcers. The metrics were used to display how trust wide quality improvements had improved the patient’s journey and experience.

The surgical care group’s quality dashboard data, fed into operational meetings. Work streams were colour rated red, amber, green, which flagged where targets were unmet and where they were achieved. For example, within the January 2018 dashboard there were 15 work streams that were red, and 29 that were green.

Engagement

Service leaders and trust wide managers engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively

There were numerous examples of how the trust had engaged patients for example to improve discharge. We saw evidence of patients’ information cards being used on wards, which had four key questions. These related to their diagnosis, ongoing investigations, discharge criteria, and expected date of discharge. Answers were completed and shared with patients.

The communication team regularly made use of social media and the trust website to advertise and broadcast trust wide events.

The trust held an annual event where patients, public, staff and governors were invited to attend. There were regular health talks for members of the public at a close location to the hospital aimed at increasing knowledge about conditions. Some surgical services provided preoperative education and advice prior to surgery, for example orthopaedic joint replacements.

There was evidence of many public consultation events as part of the recent clinical service review, the outcome was going to mean some change of location for certain services which would need further public involvement.

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

We saw and heard of many examples of innovative practice. Of those specific to surgical specialties, was the award for work force planning by the theatre team.

The acute pain team had recently started offering three sessions of cognitive behaviour therapy for orthopaedic patients prior to their surgery. This aimed to help patients develop management skills for their pain.

The orthopaedic team had just commenced in collaboration with the local university a ‘cycling against hip pain’ six-week programme. This incorporated the latest NICE guidance aimed at muscle strengthening, aerobic exercise and education as a core part of treatment for osteoarthritis.

Quality improvement methodology was being used in various surgical initiatives. These included the development of acute abdomen pathways, in surgical productivity improvements and in orthopaedics reconfiguration. There was new advanced nurse practitioner based in the surgical assessment unit, this role was focused on optimising older people ready for their surgery.

The trust had been involved in accreditation and peer reviews, which included specifically for surgery the Anaesthesia Clinical Services Accreditation which was achieved last December 2017.

The surgical team told us of ongoing research projects, these included for example, consultant led pre-assessment clinics and the use of bi polar and blue light therapy within Urology.

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**Maternity**

**Facts and data about this service**

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) offers a midwife-led maternity service from a freestanding unit on the Royal Bournemouth Hospital (RBH) site. The three bedded midwife-led unit at RBH provides birthing services for low-risk women only, with the majority of women in the area giving birth at the main obstetric unit for the region, at a neighbouring trust. Although the RBH service does not provide obstetric labour care, women access a range of antenatal and postnatal care within the trust’s maternity services, including screening and support from obstetricians. RBCH midwives discuss place of birth options with women. These include the trust’s midwife-led unit, at home with support from trust community midwives or at the neighbouring trust’s obstetric unit or alongside midwifery led unit.

Maternity services were part of a recent Dorset-wide clinical services review, and a decision had been made in September 2017 to merge Bournemouth’s maternity services with those of a neighbouring trust, and to build a new obstetric unit on the Bournemouth site. These changes, including those relating to the estate, were still in the planning phase at the time of the inspection.

For this core service inspection, we reviewed the birthing unit, an antenatal clinic and screening session and a community clinic.
We last inspected this service, in combination with gynaecology services, in 2015, and we judged these services required improvement in effectiveness and leadership. We found services did not have an effective audit programme, they were unable to demonstrate compliance with clinical standards and appraisal levels were low. Governance arrangements did not ensure quality issues and risks were identified and used to improve services. We made a requirement, under Regulation 12 of the Health and Social Care Act, that protocols must be developed for the safe evacuation of women from the birthing pool. Under Regulation 17, we required the provider to improve the clinical governance of these services.

During our visit on 13 and 14 March 2018, we spoke with 14 women and their partners and 19 staff members. Staff included senior departmental staff, midwives and maternity care assistants, non-clinical staff, doctors and managers. We looked at six sets of notes and collected two feedback cards from women attending the service.

From October 2016 to September 2017 maternity services provided antenatal care to 2,800 women and postnatal care to 2,500.

From October 2016 to September 2017 there were 126 deliveries at the trust.

A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below. Please note, the bold bar in the centre of the graph is the national average and the small bar at the far right of the bar represents this trust. As this maternity unit is a small midwife led unit, the comparative position of this trust is expected.

Number of babies delivered at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust – Comparison with other trusts in England.
A profile for gestation periods for the same period can be found below.

**Gestation periods (October 2016 to September 2017)**

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>111</td>
<td>100.0%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Deliveries (n)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>111</td>
<td>498,097</td>
</tr>
</tbody>
</table>

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

On inspection, the service reported data that differed from that shown above. The trust reported the following data on births for October 2016-September 2017:

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth centre</td>
<td>266</td>
</tr>
<tr>
<td>Home birth</td>
<td>46</td>
</tr>
<tr>
<td>In transit/other</td>
<td>29</td>
</tr>
<tr>
<td>TOTAL</td>
<td>341</td>
</tr>
</tbody>
</table>

All of the births at the birth centre were when women were between 37 and 42 weeks gestation. Outside these parameters, women gave birth at the obstetric centre at a neighbouring trust, not the birth centre.

The following table shows the number of deliveries by quarter for the last two years. We see a steady decline in the number of deliveries over the first four quarters, with a sharp drop from 60 to 28 deliveries from October to December 2016. For the remaining reported period, the number
of deliveries slightly increases but is still less than half of what was reported in 2015/2016 Q3.

**Number of deliveries at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust by quarter.**

![Bar chart showing number of deliveries by quarter](chart.png)

**SOURCE: HES - Deliveries (October 2016 - September 2017)**

The service has experienced a downward trend in births in the last 12 months, which reflects the pattern of births locally.

On inspection, the service provided a different set of data from that shown above. Their data showed a decline in the numbers of deliveries from 103 in quarter 4 2015/16 to 77 in quarter 1 2017/18.

**Is the service safe?**

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

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

**Mandatory training**

**Mandatory training completion rates**

The service provided mandatory training in key skills to all staff and monitored compliance levels.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of November 2017 for nursing/midwifery
staff in maternity is shown below:

**Mandatory training completion rates - nursing & midwifery staff**

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target</th>
<th>Number trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security, Violence &amp; Fraud</td>
<td>95%</td>
<td>57</td>
<td>57</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>WRAP Training</td>
<td>95%</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>57</td>
<td>57</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>95%</td>
<td>57</td>
<td>57</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Sharps-Level 2</td>
<td>95%</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Sharps-Level 1</td>
<td>95%</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>95%</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity &amp; Human Rights</td>
<td>95%</td>
<td>56</td>
<td>57</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>95%</td>
<td>55</td>
<td>56</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>95%</td>
<td>55</td>
<td>56</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>95%</td>
<td>109</td>
<td>113</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>95%</td>
<td>54</td>
<td>56</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95%</td>
<td>54</td>
<td>56</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>95%</td>
<td>50</td>
<td>52</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95%</td>
<td>105</td>
<td>110</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>95%</td>
<td>52</td>
<td>56</td>
<td>93%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>95%</td>
<td>51</td>
<td>56</td>
<td>91%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>95%</td>
<td>50</td>
<td>57</td>
<td>88%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an electronic system for advising staff and managers when mandatory training was due and staff said they had good access to mandatory training.

Staff said they had completed conflict resolution training to support their personal safety when working remotely or on their own. The trust had recently made sepsis and the deteriorating patient training mandatory with a new training programme launched in 2018.

When we visited, training compliance had improved in the three areas highlighted as below 95% in the above data. Compliance levels were 94% for adult basic life support, 97% for conflict resolution and 91% for fire training.

**Mandatory training completion rates - medical staff**

Trust-submitted data, which showed training, results for the 15 Obstetrics and Gynaecology staff. The results showed medical staff had completed between 60% and 93% of the mandated training courses, with an overall average completion rate of 82%, in the nine months to 31 January 2018.
In the previous financial year, the completion rates for mandatory training were 90%. This is below the trust target of 95% completion.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of November 2017 for nursing/midwifery staff in maternity is shown below:

### Safeguarding training completion rates – nursing & midwifery staff

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target</th>
<th>Number trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>55</td>
<td>57</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>54</td>
<td>56</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>51</td>
<td>56</td>
<td>91%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. When we visited, data for February showed compliance with level 3 safeguarding had 98%, showing staff were up to date their required training.

The 2016/17 Annual Safeguarding report showed that maternity services reported 44 safeguarding referrals to social care services during the year. The trust introduced an electronic referral form in 2017 to facilitate easier reporting and to help the monitoring of safeguarding referrals. Policies and procedures for safeguarding children were up to date and the trust had developed a safeguarding children work-plan for 2017/18.

Staff recognised and reported abuse and had built effective systems for working with other agencies. The service had set up a comprehensive social risk assessment, which enabled staff to identify vulnerable women including those at risk of abuse. The service had set up a ‘Sunshine’ team of midwives with specialist expertise in supporting vulnerable women and families. There was a referral pathway to the sunshine team based on the overall risk assessment. The Sunshine team had undergone some changes in the past year. There were fewer staff in the team, and they all held some low risk women in their caseloads. Following triage, all community midwives carried a small caseload of medium risk women in their caseloads. This arrangement was intended to give midwives a broader range of experiences in safeguarding procedures. The Sunshine team had developed good links across health and social care services, the police and education services. They were able to offer additional care to women and facilitate early contact with health visitors to help the handover process. We reviewed records that demonstrated midwives completed the safeguarding risk assessments and there was a referral pathway to the Sunshine team.
There had been one serious case review for maternity services in the past year. The report had just been published at the time of our inspection and learning from the case was shared and cascaded through the risk meetings to all staff.

Within maternity services, the head of midwifery, and the named nurse for safeguarding children and the lead midwife for safeguarding had been trained to level 4 in children's safeguarding. The service also had a named consultant lead for safeguarding and a lead midwife. The named nurse for safeguarding children provided safeguarding supervision, for groups or individual staff.

The service had developed a safeguarding children policy for midwives. This was linked to the trust policies and the guidelines of the Poole and Bournemouth safeguarding children board, the Dorset safeguarding children board and Hampshire's local safeguarding children board. At booking, midwives took a full social history and completed social risk assessments. They shared these with the health visitor after the birth, as well as with the safeguarding lead midwife if they identified concerns.

Staff carried out a social risk assessment at the booking appointment, where they sensitively identified any risks associated with, for example, physical or mental abuse including female genital mutilation, and teenage pregnancy. There were trust policies and procedures to follow which related to domestic abuse, female genital mutilation and child sexual exploitation.

The service had a policy for following up with women who did not attend for appointments. The ‘Do not attend’ policy meant that if a women did not attend for a clinic, and still did not attend after three attempts by the midwife, their case was transferred to the Sunshine team for more individualised support.

**Safeguarding training completion rates - medical staff**

All eligible staff were up to date with training in safeguarding adults level 2, safeguarding children levels 1, 2 and 3 in 2016/17 and 2015/16. The trust required staff to complete update training every three years. In the nine months from 1 April 2017 to 30 January 2018, 70% of medical staff had completed their required safeguarding training.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All areas of the birth centre were visibly clean and uncluttered. Storage areas were well organised to support cleaning. We observed the use of ‘I am clean’ labels on equipment prepared for use. The service provided evidence of cleaning regimes and cleaning logs for the antenatal clinic and birth centre. The infection control team regularly swabbed different items of equipment, to evaluate their cleanliness. If the swab showed a failed test result, the staff were informed to carry out more effective cleaning.

Midwives had good access to personal protective equipment such as gloves and aprons, and we observed appropriate hand hygiene practices. Clinical areas had antibacterial hand gel dispensers at their entrances.

Staff complied with the trust’s policy of being bare below the elbows and data showed all staff were up to date with infection prevention training.

Hand hygiene audits within the antenatal clinic, carried out by the infection control team, reported 95% compliance in December 2017, but compliance declined in January 2018 and February 2018. The service had implemented an action plan and increased audit frequency to improve
compliance. Maternity care assistants (MCA) conducted monthly hand hygiene observations, where they observed midwives and MCAs on 10 occasions. The reports were submitted online to the infection control team. The results indicated good infection control activities.

Midwives encouraged women to visit their GP for vaccination against flu and pertussis (whooping cough), with information and leaflets given at booking. As the Bournemouth maternity service was for low risk women, any women with signs of infection or sepsis were transferred to a neighbouring trust’s obstetric unit for care.

Community midwives and the homebirth team used specially designed, disposable boxes for the removal of placentas. They disposed of these sealed, labelled boxes at the birth centre as clinical waste. If further testing was required, the boxes were sent to the laboratory for testing.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

The birth centre had its own entrance and reception area, with staff offices, clean and dirty utility rooms, a small kitchen and toilets. There was parking adjacent to the building. The unit was freestanding, but located close to the hospital main building. It had two large, well-appointed and spacious birthing rooms each with a purpose-designed pool for water births. There was a smaller, third room for postnatal care and baby observations. The unit had a birthing chair and a range of relaxation equipment to offer women in labour. We observed that all equipment was in good condition.

Each birthing room was equipped with suction equipment and piped oxygen. Portable electrical equipment displayed evidence of safety testing.

Staff could describe the birthing pool evacuation procedure and there was a written policy and protocol on the unit for reference. The service had created a training video to demonstrate the procedure, and this was part of the mandatory update training. Staff had completed evacuation simulation drills with the clinical site team.

Emergency equipment was accessible in the birthing unit and we saw staff checked the equipment on the adult resuscitation trolley and two baby resuscitaires each day (a resuscitaire is a warming platform used to assist in the resuscitation of new-born babies). When completing these checklists, staff added notes of any consumables that were approaching their expiry dates and needed to be replaced. This helped ensure all stock was maintained in date.

There was appropriate equipment on the emergency trolley, including infusion sets and items for massive obstetric haemorrhage. The unit also maintained an emergency transfer bag, prepared for when women and babies were transferred to a neighbouring trust’s obstetric unit. Staff said there was no checklist for the items in this bag. This meant there was a risk that all necessary items might not be available.

Other safety equipment in the unit included a jaundice monitor, emergency boxes for anaphylaxis and hypoglycaemia and glucose meters.

The antenatal clinic was in the main hospital and staff had identified a lack of space for women waiting for appointments and insufficient clinical rooms for the numbers of women attending. This was on the service risk register and mitigating actions had been put, which included the way the appointments were managed.

There was a standard antenatal/postnatal/delivery equipment list for each community midwife and systems were in place to ensure items of equipment were regularly serviced or replaced. The service maintained a log, which showed when staff had completed training in the use of
equipment. This included general equipment such as blood glucose monitors and the defibrillator, as well as specific maternity equipment such as fetal monitors and bilirubinmeters. Staff signed to show the equipment they had received, and when it was last calibrated.

Midwives had smart phones with a specific application to use if they felt unsafe working in the community.

### Assessing and responding to patient risk

Midwives carried out detailed risk assessments, from the booking appointment onwards, kept clear records and asked for support when necessary. Women attended the booking appointments at 8-10 weeks gestation, in community clinics, and they attended the hospital clinics for scans and blood tests between 11 and 14 weeks.

The service operated a system for booking women for their first antenatal blood screening, using the maternity IT system, which provided a cross check to ensure women were safely booked onto the system. Women also attended the antenatal clinic for their first trimester screening session.

The risk assessments were standardised across Dorset. Midwives carried out assessments of women’s social, health and environmental risks at the booking appointment and recorded results in the women’s records. The social risk assessments included assessments of women’s home circumstances, for example risks relating to housing and close family. Midwives also took account of women’s physical and mental health risks, risks of thrombosis (heart attack) and any obstetric or gynaecological risks. The risk assessment process was mapped out within the pre-printed notes booklet, and we observed midwives used these to ensure they carried out comprehensive assessments with women. Midwives referred women to the consultant midwife, based at a neighbouring trust, or obstetricians based on the outcome of the risk assessments.

Initial booking risk assessments and ongoing screening meant staff identified abnormalities or raised risk factors. These were then discussed and care planned with all relevant parties, including the women and their partners

Midwives had access to notes, ultrasound scans and blood test results on their IT system, which helped them review women’s care and monitor risks, including when appointments were held in the community clinics. When we reviewed records, we found evidence that staff had completed these risk assessments and recorded associated action plans.

Staff monitored women’s blood pressure, weight and fetal growth at each appointment. They reassessed risk factors as appropriate. The risk assessment process included an escalation procedure to refer women to an obstetric consultant clinic, for example to discuss the place of birth options if the midwife’s assessments identified increased risk factors. The midwife-led unit and home birth services was designed to support only low risk women in labour. We saw that staff created detailed records of conversations with women, for example when women chose a higher-risk birth option than recommended by staff.

Midwives at the birth centre used partograms to record observations and monitor the progress of labour. This assessment tool enabled staff to identify and respond to a patient whose health was deteriorating and might require transfer to the obstetric unit for additional medical support. The midwives used an early warning assessment tool, known as the modified obstetric early warning score, (MEOWS) when a woman at the birth centre experienced a post-partum haemorrhage.

The service had detailed guidelines for the care of low risk women in labour, which applied across the obstetric units, birth centres and home births. These included monitoring clinical indicators and the triggers for midwives to change the frequency of monitoring or to initiate a transfer to the obstetric unit.
The service had developed an agreement with the ambulance service to ensure they gave women who required transfer to the neighbouring obstetric unit a priority. This was based on agreed assessments completed by midwives. Staff reported they knew the emergency reference code to use when calling the ambulance service and said the site team also provided good support.

All staff we spoke with were aware of the circumstances in which it would be necessary to transfer a woman or baby from a home birth or the birth centre to the obstetric unit. Staff told us midwife escorts were always sent with the ambulance crew.

The community midwives carried out new-born and infant physical examination screenings (NIPE) within 72 hours, to identify any developmental risks.

**Midwifery and nurse staffing**

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

The trust has reported their staffing numbers below for the period April 2017 to November 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff establishment</th>
<th>WTE Staff actual November 2017</th>
<th>Number in post as at November 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Bournemouth General Hospital</td>
<td>42.0</td>
<td>41.02</td>
<td>50.0</td>
</tr>
<tr>
<td>Total</td>
<td>42.0</td>
<td>41.02</td>
<td>50.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The above data showed the trust had almost recruited to its establishment in November 2017. The service was exploring how to share staff across RBCH and the neighbouring Hospital, giving due consideration to contract arrangements. This was being set up for ‘newborn and infant physical examination’ (NIPE) team.

Community midwives carried caseloads of up to 100 women, some of whom would give birth at the neighbouring hospital. The service had revised caseload protocols, such that staff assessed the risk level of each woman and referred higher risk women to their Sunshine Team, with medium risk women held under the caseloads of the community team. Staff within the sunshine team held a small cohort (40 maximum) of low risk women in their caseload. This move was designed to enhance staff skills in safeguarding practices, so all maternity staff were able to support vulnerable women.

Managers and staff said there were enough staff, however it was acknowledged that the Sunshine team was waiting for newly appointed staff to start in role.

The service had revised staff rotas in response to feedback. Staff on call finished their day shift at 2pm, and if they were called at night they could take back time the following day. Staff said this meant they were less tired during their days off and welcomed the change. The community team coordinator was able to flex rotas to make this work whilst maintaining cover. The community midwives also supported the birth unit if required.

There was a dedicated team of six midwives assigned to the birthing unit, including a clinical lead. The service allocated an experienced midwife to lead each shift. The head of midwifery arranged staffing rotas to ensure 24/7 cover, with a ‘first’ midwife allocated to the birth centre 24/7 with a maternity care assistant. The second midwife was on call from the community team. Between 5-8pm, there was an on call midwife, and between 8pm and 8am a duty midwife and an on-call midwife.
Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a vacancy rate of -5% for nursing and midwifery staff in maternity at Royal Bournemouth General Hospital.

Please note, the trust did not provide us with an overall target for vacancy.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

On inspection, we were told there was one vacancy in community team, as a result of maternity leave, and one vacancy in the birth centre. The data suggested midwifery staffing was slightly above the planned level.

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported an annual turnover rate of 4.3% for nursing staff in maternity at Royal Bournemouth Hospital, which is worse than the trust target of 1%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The head of midwifery said that although turnover rates were low, they were proud that midwives left for promotional opportunities. During the year April 2017 to March 2018, three staff members had left the service; two midwives and one maternity care assistant, with a senior clinical lead leaving for a secondment to a matron role.

Sickness rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a sickness rate of 2.6% for nursing staff in maternity at the Royal Bournemouth General Hospital. This is lower than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided any information on bank and agency staff usage for maternity. Inspectors should clarify if this is due to there being no bank or agency staff used during the reported period.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Maternity services at RBCH did not use agency staff and used bank staff who had either previously worked for the service or staff from their own permanent staff team working on the bank. The main reasons for using bank staff was to cover vacancies or staff on maternity leave.
Midwife to birth ratio

Based on the Birth Rate Plus calculation, as of September 2017, the trust has a ratio of 4.1 births for every midwife. The national average is 26.8.

(Source: Electronic Staff Records – ESR Data Warehouse)

The above data shows a low rate of births for every midwife. However, Birth Rate Plus calculation is not wholly applicable to the services provided at this trust because the service provided maternity led care, with most women giving birth at the neighbouring trust’s obstetric unit. The trust had calculated that their actual midwife to birth ratio was 1:20.

The service monitored the caseloads of midwives. The service aimed to achieve a midwife to birth ratio of 1:1 care in labour and two midwives present for each birth. The service had an escalation policy and guidance to follow if situations arose that made this staffing model difficult. This included liaising with the neighbouring hospital and the ambulance service to arrange diversions. The unit was staffed by one midwife and one MCA 24/7, to ensure it was able to provide consistent 1:1 care. The service planned staffing rota to have three midwives available in the evening to provider cover. Overnight, they operated with a midwife from the homebirth team on call, and two community midwives and clinical leads ready to provide cover. The service also offered support to the neighbouring trusts when they were busy. The service received low risk women for delivery at the birthing unit, if capacity allowed, when requested. The service log showed there had been 14 requests from neighbouring units to divert women to the birth centre in labour in a three-month period.

Medical staffing

The maternity unit at the trust is midwife-led with all obstetric led procedures and emergency care being carried out at the neighbouring NHS trust. No staffing information for medical staff within maternity has been provided. Please request this when inspecting.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Obstetricians employed by the trust were jointly appointed with the neighbouring trust, where they also held labour ward sessions and provided on-call services under a service level agreement (SLA). Four obstetric consultants, employed by the trust, worked partly at the neighbouring trust, under a SLA. Two consultants from the neighbouring trust provided regular fetal medicine clinics and antenatal clinics at RBH.

There were no obstetricians at the trust to support midwives if complications arose in labour. In those circumstances, the service transferred women by ambulance to the obstetric service at the neighbouring hospital. A mix of both RBH and Poole hospital obstetric staff provided cover at weekends, evenings and at night at the obstetric unit. Obstetricians provided weekday clinics at RBH. This service consisted of six funded consultants (with one vacancy covering by an acting up specialist registrar), three registrars, two clinical fellows and a rotation of four specialty trainees.

All medical staff had completed an annual appraisal and they had achieved 91% compliance with statutory and mandatory training. However, the trust has assigned these staff members to the gynaecology core service. Therefore, all HR data pertaining to these staff members will not form
part of the maternity core service data.

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, this information has not been provided by the trust. Please request during the inspection.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

Sickness rates amongst medical staff were generally below the trust target of 3%, at between zero and 2%, but had spiked in December and January 2017 to 6-8%.

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided any information on bank and agency staff usage for maternity. Inspectors should clarify if this is due to there being no bank or agency staff used during the reported period.

*(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)*

**Records**

Staff kept detailed records of women’s care and treatment. Records were clear and up to date, with guidance on how to file documents and create robust records. Midwives provided women with a comprehensive booklet at their initial booking appointment, which were intended for use at every subsequent appointment with health professionals. The booklets had been created jointly with the maternity unit in the neighbouring hospital and were designed for both midwife and consultant-led care pathways, to support coordinated care. Maternity staff at both trusts could access women’s records electronically through a shared IT system.

Women kept their own paper care records and midwives also entered each woman’s booking and delivery details into the electronic system. The electronic system was set up so that community midwives could review data such as blood results and ultrasound scans at clinics. We observed that if women forgot to bring this booklet to an antenatal clinic appointment, midwives had blank supplementary sheets they could complete, with copies for the women to add to their notes, to reduce the risk of lost records.

The booklets provided a comprehensive pack of information for women, as well as templates and checklists for healthcare professionals to complete relating to risk assessments, scan results, intrapartum and post-natal care and progress. The booklets included front-cover alerts relating to risk factors such as safeguarding. They also included tear-off copies of referral forms for hospital appointments.

The service’s IT system ‘flagged’ vulnerable women so that midwives were alerted to safety issues, whether these were related to the woman’s pregnancy or their social history.

We looked at six sets of records, including a selection relating to women with complex medical or social histories. We found they were clearly completed and included the relevant information for informed decision-making. They included options and choices discussed and any decisions made. Entries were legible and detailed where necessary. For example, they included women’s preferences, medical histories and evidence of input from associated services.
**Medicines**
The service followed best practice when giving, recording and storing medicines.

Medicines were held securely, within a locked treatment room. The pharmacy team had a system for monitoring the temperature of the locked medicine fridge, by downloading a monthly record. Staff on the unit monitored the temperatures of the fridge and the room each day to ensure they were held within the correct temperature ranges. There was guidance on the fridge door on the safe temperature range and what actions to take if the results were outside the range.

Some oxytocics (medicines used to help prevent post-birth bleeding) were held in the emergency trolley. Although they have a longer life if stored in a fridge, they can be safely stored at room temperature for limited periods. We saw dates for disposal marked on the drugs, based on a reduced storage period of 4 weeks maximum.

Records included whether women had any allergies, their risks of venous thromboembolism and any prophylaxis prescribed.

**Incidents**
The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt. When things went wrong, staff apologised and gave women and their families honest information and suitable support.

Between November 2016 and October 2017, the service reported 329 incidents, 95.4% of which were recorded as no harm. The remainder were recorded as low harm. Most incidents (37%) related to access, admission, transfer and discharge and 30% related to treatment or procedure. Staff reported a transfer from home or the birthing unit to the nearby obstetric unit as an incident. The next largest type of incidents, 8%, related to documentation. Throughout the year, there was no upward or downward trend in the numbers of incidents reported. Incidents were reported in a relatively timely way, with 67% of incidents reported within 14 days and 86% within 30 days.

The head of midwifery, the obstetric lead for governance and clinical leads reviewed all reported incidents. The governance lead tabled specific incidents for wider clinical discussion at the fortnightly open risk meetings, to improve learning and practice.

Obstetric staff at the trust joined the monthly hospital mortality and morbidity meetings held at the nearby trust, via a video link, to share learning. For example, there was shared learning relating to the care of a woman with diabetes.

Staff could explain how they reported incidents and near misses, using an online system, and said they understood the value of incident reporting. They said the system prompted consideration of the Duty of Candour, and there was an online toolkit for reference, or they could seek advice from the quality and risk team.

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

From January 2017 to December 2017, the trust reported no incidents which were classified as never events for maternity.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in maternity, which met the reporting criteria set by NHS England from January 2017 to December 2017.

This incident related to staff sharing confidential information by email without adhering to the correct data protection protocols.

There had been two serious incidents in the past year, one reported outside the data set referred to above. One related to a failure to refer a woman with a chromosomal disorder for further follow up in a timely way. The woman had seen the community midwife and been correctly referred to a consultant in this pregnancy at 8 weeks gestation but was not seen until 25 weeks. The service reviewed the incident through the root cause analysis procedure and duty of candour had been considered. The service ensured it shared lessons learnt. The other serious incident related to a confidential private information breach, when the internal auditors had requested information from the service. The maternity service identified and reported the breach and there had been a full root cause analysis and learning from the incident. This process included discussion relating to duty of candour and the production of an information sheet for shared learning.

Safety thermometer

The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. Data was collected on a single day each month to indicate performance in key safety areas. The maternity safety thermometer measures harm from perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.

Maternity services at RBCH focused on the infection control aspects of the safety thermometer and carried out hand hygiene and equipment swabs.

Is the service effective?

Evidence-based care and treatment

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

Women had comprehensive assessments of their needs, which included consideration of their health, social, wellbeing and emotional needs. We reviewed the records for six women and saw that care was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines for antenatal care for uncomplicated pregnancies. The women’s records included reference to NICE guidance and the risk assessments aligned to risks listed in the clinical guideline CG62.
The service had implemented NHS England’s Saving Babies’ Lives care bundle. This package of care is based on best practice guidance on reducing the risk of stillbirths. The key elements are to reduce smoking in pregnancy and monitoring fetal growth and movement. At antenatal appointments, midwives prompted women to monitor fetal movements and to seek advice if concerned, providing practical guidance. There was detailed printed information on how to monitor fetal movements in the women’s records, for reference.

Midwives monitored fetal growth using the fundal height measurement (from the top of the mother’s uterus to the top of the mother’s pubic bone), and plotted this using customised growth charts. The service also carried out detailed ultrasound in the first and second trimester of pregnancy. The service used the national Gestation Related Optimal Weight (GROW) charts, in accordance with the Perinatal Institute recommendations. Adjustment for the GROW variables improves the recognition of babies that are pathologically small or growth restricted. Fetal growth restriction is associated with stillbirth, neonatal death and perinatal morbidity. This approach helped midwives identify growth retardation. If they had concerns, they referred women for further scans and follow up as necessary.

The service provided additional support for women with risk factors associated with social vulnerabilities and implemented personalised care plans through their Sunshine team of specialist midwives. This is in accordance with MBRRACE-UK perinatal report 2015. In addition, midwives screened for women with a high BMI, smoking and diabetes, as well as many other risk factors, which indicated referral to obstetric assessment. The trust’s specialist midwife for diabetes supported women throughout their pregnancy.

The trust was in the process of reviewing all maternity policies, as part of the Dorset Vanguard work stream, to produce consistent policies across the county. Some policies were at draft stage as a result, pending decisions in May 2018 on how this work should be progressed. The service was following their draft policies in the interim.

The service updated their guidelines on normal labour and birth in 2017, and again in 2018, as part of this work stream. The guidelines reflected department of health and latest NICE guidance on women’s choices on place of birth and care for healthy women and babies (2017). It included guidance on the use of cardiotocography and the clinical conditions indicating the need for urgent transfer to the nearby obstetric unit.

NICE guidance also recommends midwives encourage breastfeeding and support women with breastfeeding as soon as possible after the birth. The service had a structured approach to encouraging breastfeeding, and there was clear information about the benefits and support available to help women to breastfeed. The service had three trained maternity care advisors to provide additional support where needed.

Community midwives carried out the newborn and infant physical examination (NIPE) checks within 72 hours of the birth, in line with UK Public Health England Screening programme. These included a physical examination to check the baby’s eyes, heart, hips and, for boys, their testicles. Staff referred babies for further medical investigation, treatment or care as required. The service applied the NIPE failsafe process, to track babies through the system. The midwives also carried these out on the babies in their caseload who were born in the labour ward at the nearby hospital.
**Nutrition and hydration**

Staff gave women enough food and drink to meet their needs during labour.

There was food available for women at the unit from the hospital canteen and there was a kitchen for women and their birth partners to use.

Midwives gave women informed information on their choices on how to feed their babies, whilst encouraging breastfeeding as offering the most benefits. They offered support with breastfeeding and signposted women to further resources after discharge. Midwives assessed how women managed to feed their babies following birth and again at the subsequent post-natal appointments. The records booklet included a breastfeeding assessment form.

**Pain relief**

Staff assessed and monitored women to see if they were in pain and gave additional pain relief to ease pain.

The service had guidelines on the types of pain relief appropriate to offer and advise women at different stages of labour. The guidelines also stated that women’s views on pain relief should be respected even if not advised.

Midwives discussed women’s preferences for pain relief as part of the birth plan. There were birthing pools in the birth centre’s two main birthing rooms that women could use as pain relief in labour. If necessary, midwives gave pethidine injections to help women relax during labour, in line with the service guidelines. The service did not offer epidurals, and midwives advised women of this in antenatal clinics and explained when and where this type of pain relief could be provided.

Community midwives could offer women pain relief in the form of gas and air (entonox) for home births. Women could also use a warm bath or hire their own birthing pool for relaxation and pain relief.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to implement improvements.

There had been no maternal deaths recorded in the service in the last three years.

The service had achieved 1:1 care for all women giving birth in the birth unit or at home in the past year. The service also met the target for seeing women within five days within the fetal medicine unit when they were referred.

The service has worked collaboratively with the ambulance service to update the transfer policy and improve the emergency transfer response time. As a result, the services had agreed priority categories for women needing to be transferred to an obstetric unit. We were told the current transfer rates were 23% (January 2018) and 39% (February 2018) for women who were pregnant for the first time. For women who had a baby previously, the trust transferred 0% in January 2018 and 3% in February 2018, against the Birth Place Study average of 9%. For women who were pregnant for the first time we were told the transfer rates were 23% (January 2018) and 39% (February 2018). The Birth Place Study outcome showed a national average of transfers of 36%. 
Midwives undertook a range of audits, with facilitators to coordinate and assist the process. The trust’s audit department staff supported and monitored the maternity audit programme.

The service had participated in the clinical audit ‘Mothers and babies: reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) in 2017, aimed at reducing mortality rates. The service identified areas for improvement, which included updating specific policies and completing mandatory training in key skills where there were a few omissions. The service planned to achieve compliance by April 2018.

The service had audited the use of pethidine for pain relief in labour. As a result of the audit, the service had identified four actions to complete. These were to develop information about pain management strategies, invite women to visit the birth centre, update the relevant policy and offer home assessment in labour where possible. At the time of the inspection, midwives had increased the opportunities for women to visit the birth centre and policy updates were in progress.

The service had completed an audit of the Grow policy in 2017, and results were as expected. The audit lead planned to adapt the subsequent re-audit in April 2018 with further questions, to improve learning.

The service had audited practices under the Saving Babies’ Lives programme. For example, the service audited smoking rates amongst women as smoking has been shown to be detrimental to the health of women and babies. The midwives carried out for carbon monoxide tests with women and referred them to a stop smoking specialist. There had been a year on year downward trend in smoking amongst women. In 2016/17, 11.2% women smoked at time of delivery, and this had reduced to 8.4% in 2017/18.

The service undertook the improvement activity promoted by Wessex clinical network to detect fetal growth restriction. It identified in needed to improve the rate of discussing fetal movement with pregnant women at every contact, and the service texted women information about fetal movement as a reminder.

The service carried out local audits to identify areas of improvement. For example, staff initiated a retrospective audit of postpartum haemorrhage (PPH) in November 2017, as the rate of PPH had remained at 6% for three years. The results showed areas of good practice and actions for improving the outcomes for women at the third stage of labour. The service had updated the policy, flow chart and documentation and planned to re-audit this in September 2018. Staff had re-audited suturing practice in 2017 and found all staff used the suturing proforma, but there were areas left incomplete. The finding had been communicated to help improve recording practices.

As a ‘Better Births’ early adopter, working jointly with other hospitals, the service had improved the continuity of postnatal care. The service had developed new postnatal guidelines, with the aim of improving continuity of care for women and offering a more flexible service. Under the new guidelines, the service and women could negotiate an agreed discharge date, between 10 and 30 days after the birth. This enabled midwives to arrange appointments when mutually convenient and provide extended support where requested. Results showed that 80% of women saw fewer than three midwives for antenatal and postnatal care. This meant the service was meeting its standard for continuity of care.
The service had used the trust's policies for the management of Sepsis, but were reviewing the use of the Sepsis policies from neighbouring obstetric unit. The policy was to refer patients to the obstetric unit if they showed signs of Sepsis and to uses the MEWS and MEOWS assessments. Midwives also gave women advice on the symptoms of sepsis as part of the discharge checklist.

Maternity services shared learning from audits at the regular open risk meeting minutes and team meetings and newsletters.

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

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust maternity unit is a midwifery-led service based at the Royal Bournemouth General Hospital. All 126 deliveries at the trust were non-interventional or emergency caesarean section deliveries; there were no instrumental deliveries. Elective caesarean sections for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust were carried out at the neighbouring trust's obstetric unit.

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

**Maternity active outlier alerts**

As of January 2018, the trust reported no active maternity outliers. There had been no maternity alerts since the CQC outliers programme first started.

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

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)**

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 3.37. The comparator group was 3.41.

(Source: MBRRACE UK)

The service was committed to reducing the risks of stillbirths, by carrying out detailed risk assessments and monitoring fetal movements and growth rates.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support.

**Appraisal rates**

From December 2016 to November 2017, 100% of staff within maternity at the trust had received an appraisal compared to a trust target of 90%.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td></td>
<td></td>
<td></td>
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<td>-----</td>
<td>------</td>
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<td>------</td>
<td></td>
</tr>
<tr>
<td>Community Midwives</td>
<td>33</td>
<td>33</td>
<td>100%</td>
<td>90%</td>
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</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>18</td>
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<td>100%</td>
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<tr>
<td>Support to doctors and nursing staff</td>
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<td>11</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
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<td>5</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>NHS infrastructure support</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff said the appraisal process was meaningful and could cite examples of how they had gained additional responsibilities or training following their appraisal discussion. Two recently appointed staff also told us they had experienced a thorough induction to their roles, and that they had good support from colleagues.

Staff said they received good training in their roles. The service had shown a consistent year on year improvement over the past three years, from 87% to 93% up to 97%, in completion of all training modules. The service had appointed a practice development midwife, who reviewed practices and delivered skills and drills training to promote safe working practices for community and birth centre staff. Staff told us this had been beneficial in improving the safety culture of the service, especially as the skills and drills were done jointly with ambulance staff and the site team. This helped develop a collaborative approach to emergency maternity care.

Staff had also joined with the maternity team from the neighbouring trust to undertake human factors training and emergency scenario training, following the PROMPT model (Practical Obstetric Multi-professional Training) to improve outcomes for women and babies. Joint working with the neighbouring trust had also enabled some of the staff from the birth centre to qualify to undertake Newborn Infant Physical Examination checks.

The service provided dedicated training days for maternity care assistants (MCAs), and on-line training resources. MCAs also completed competency assessments for roles such as breast feeding support.

Midwives were trained to carry out the NIPE checks, including the majority of midwives in the birthing unit.

All staff reported good access to role-specific training, such as how to help babies with tongue-tie to feed. Two midwives were training to be Professional Midwifery Advocates, to deliver a supervisory role that empowers midwives to provide high quality, personalised and compassionate care.
Multidisciplinary working

Staff in different roles worked together as a team to benefit women and babies. The midwives and MCAs described good working relationships across different trust staff, and between maternity staff at the neighbouring trust. They described effective multidisciplinary (MDT) working with health visitors, GPs, ambulance services and social services. This had been enhanced by joint training events across different services. Maternity services had recently collaborated with the ambulance service to agree the transfer protocols to improve outcomes for women and babies. The service was also planning to restructure community midwifery, to align their areas of work with those of health visitors, to improve service links and continuity of care for women.

The lead midwife for safeguarding and Sunshine team had developed strong links with external agencies, which included social services, the police and services supporting vulnerable women. Staff were able to give examples of when they had worked together to support women with specific care needs. For example, they reported good interagency working to help a woman who had left an abusive relationship.

Maternity services had developed effective partnership working with the perinatal mental health team and the service had recently updated the domestic abuse maternity guideline in liaison with other agencies.

The service worked closely with the maternity services at the nearby trust, for example referring women to the consultant midwife there to support women with complex birth plans. The two trusts also held joint monthly mortality and morbidity meetings, via video link, joint obstetric meetings and joint antenatal and newborn screening committee meetings. Staff described how closer joint working supported shared learning when things went wrong and created opportunities for sharing good practices. The trust’s mortality review policy does not however include reference to this shared approach to learning from perinatal and maternal deaths.

Seven-day services

Maternity services were planned to support 24/7 labour support. The service participated in the Dorset-wide out of hours ‘labour line’. This is a 24-hour telephone service hosted by midwives based at the neighbouring trust, which The Royal Bournemouth and Christchurch NHS Foundation Trust supported.

Health promotion

Staff supported women to live healthier lives and helped them provide a healthy start in life for their babies.

...This was though their work on smoking cessation and breast feeding support. They also discussed vaccination benefits with women and promoted mental health services. For example, the specialist consultant lead from the local mother and baby unit offered a perinatal mental health multidisciplinary clinic. The service also had specialist links, and close working, with agencies for referral to drug and alcohol services.
The ‘pregnancy information nutrition and exercise’ (PINE) clinic provided additional support for women with raised BMI above 35. This was led by a specialist registrar and midwives.

The service sent ‘Kicks count’ texts sent to all women to promote fetal movement awareness, in addition to their routine antenatal assessments.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

Information on Mental Health Act (MHA) training and Deprivation of Liberty Safeguards (DoLS) training has not been provided by the trust. Please request this during the inspection.

*(Source: Trust Provider Information Request P14/P49)*

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They followed trust policy and procedures when a woman could not give consent.

Trust guidance on normal labour and birth stated that midwives must listen to women’s wishes relating to an emergency transfer and obtain consent. If a woman chose not to follow the advice, there was guidance for midwives to respect and record this decision and report an incident.

We reviewed six sets of records, including those of women with complex medical and/or social histories, to assess how staff gained their consent. Records showed that staff explained the risks and benefits of different birth options and when appropriate, staff recorded what women had or had not consented to. Notes showed when parents declined medical advice, for example on where to give birth, and there was clear records describing this.

Staff recorded consent to interventions such as blood tests and, for example, if staff suggested daily post-natal home visits.

**Is the service caring?**

**Compassionate care**

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

**Friends and Family test performance**

*Friends and family test performance (antenatal), The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*
From November 2016 to October 2017 the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

**Friends and family test performance (birth), The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust**

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to, but consistently above, the England average.

**Friends and family test performance (postnatal community), The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust**

From October 2016 to October 2017 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. There were not enough comments to report on it in February 2017.

(Source: NHS England Friends and Family Test)

The service was proud of its Friends and Family test results and displayed results in the birth centre. In February 2018 for example, the service received 42 feedback cards for antenatal care in the community, 47 for post-natal care in the community and 16 from women using the birthing unit. Over 95% of responders said they would recommend the services, with 100% recommending the birthing unit.
Women said they had been told they could text the midwife for information or with queries at any time, and they found this reassuring. One woman said they had seen the same midwife for their five antenatal appointments and she was very happy with the care she received. We observed that midwives explained their observations and gave advice in a kind and non-judgemental manner, for example when offering support with smoking cessation.

Women made the following comments about their care and staff: ‘Lovely staff, kind, and easy to talk to,’ ‘very personal and put me at my ease’ and ‘supportive and kind’.

From our reviews of records, we noted that staff explained risks and benefits of different options and also recorded if women declined to follow medical advice. It was clear that staff maintained good relationships with women in these circumstances, and continued to provide compassionate, personalised care.

**Emotional support**

Staff provided emotional support to women to minimise their distress.

One woman told us they had sought additional reassurance from both the labour line and a midwife in the emergency department, and said staff had been consistently kind and compassionate.

We read letters women had written to the service which described how staff had helped them when they had been frightened and this meant they had a better birth experience than they had hoped for. The letters were positive about the emotional support women had received.

We reviewed the records for a woman who had a complex mental health and social history. It was evident that the woman’s views were taken into account and her birth preferences were listened to. Postnatally, staff referred her to different services to provide ongoing emotional and psychological support.

The service had a specialist bereavement midwife to individualised care to each family. The trust showed us an example of a letter of appreciation from a bereaved family.

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

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

Women told us that midwives explained how the clinics worked and what to expect and what to consider. They felt they were given the right amount of information at the right time. This helped them understand the options and encouraged them to talk about preferences and concerns.

The maternity team offered women opportunities to visit the birth centre and meet with them. They offered ‘classes’ on topics such as labour, birth and pain relief and feeding sessions.

We observed midwives talked with women in an open and supportive way. They offered practical advice; for example, what to do when moving house in order to maintain continuity of antenatal care. They also talked through practical tips on how to link with other health services. For example, how to arrange whooping cough and flu vaccinations.
The Friends and Family responses from the community clinics included comments such as ‘felt listened to’, ‘always felt valued’, ‘listened to and included’ and ‘gone above and beyond’.

Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy

From April 2016 to September 2017, the bed occupancy levels for maternity were much lower than the England average. Bed occupancy at the trust’s birthing unit fluctuated between 20 to 30%, while the England average maintains a steady rate of around 60%.

The chart below shows the occupancy levels compared to the England average over the period.

Bed occupancy levels compared to the England average

(Source: NHS England)

The data above shows a low bed occupancy rate. This is because the service provided a maternity led service only, offering women a choice of a home birth, birth in its standalone birth centre or birth in the labour ward of the neighbouring trust.

The trust planned and provided services in liaison with the wider health economy to meet the needs of local women.

Maternity services were interconnected across Dorset, and the outcome of the clinical services review meant the links were increasing. Royal Bournemouth and Christchurch NHS Trust (RBCH) provided antenatal and post-natal services to women in the Bournemouth area. The trust’s birthing options were limited to the midwifery-led birth unit or home births. The trust had reviewed its
service delivery model in the last two years in line with NICE guidance and updated protocols to advise higher-risk women to give birth at the obstetric unit at the nearby NHS trust.

As a result, most women gave birth in the obstetric labour wards at the nearby obstetric unit, and the bed occupancy at the Bournemouth birth centre was relatively low. However, staff were trying to promote its use through inviting women and their partners to view the centre and to attend ‘meet the midwife’ information sessions. Midwives held these drop in sessions twice a month and offered low-risk women the opportunity to meet the birth unit team and learn more about the facilities on offer at the midwife led unit.

The service supported women with risks from mental health diagnoses and drug and alcohol abuse. The multidisciplinary support team had reviewed the timing of specialist clinic times to improve attendance and care planning.

Women with more complex medical needs were seen at Royal Bournemouth Hospital for routine care within the antenatal pathway, all women requiring urgent high risk interventions, or if high risk intrapartum care were referred to the nearby obstetric unit. The maternity services at RBCH supported vulnerable women through their pregnancy, for example those living with a learning disability or teenagers. There was effective joint working across both trusts.

The service aimed to support women to have their care in the community as much as possible. Community midwives offered clinic appointments at a variety of venues which improved the convenience for women. For example they held clinics at medical centres and children centres, booked via GPs or online or using the trust referral line. There were two community teams, based in East and West of the local area. The service aimed to restructure slightly, to offer a service that geographically matched that provided by the health visitor service, with the aim of improving continuity of care for women. We received positive feedback from patients we spoke with about the convenience of community clinics.

The service reported that the providing appointments in children centres had improved women’s engagement with additional services. For example, family support workers offered specialist groups for women with low level anxiety and depression throughout their pregnancy and up to three years post-delivery. As a result of this partnership, and other engagement work with the children’s centres, Bournemouth Borough Council awarded maternity services as the overall Children's Centre Partner in 2017.

In response to a local increase in women who were street homeless, which had proved a new challenge to the Sunshine team and in order to ensure the women had appropriate support the team had set up a new partnership working with a local street homeless team.

The women’s notes included signposts promoting the My Birthplace app. This smart phone application enabled women to obtain guidance on the places for giving birth in their local area. The app described risks and benefits for choosing to give birth at home, in a midwifery led unit or with consultant led care. It included a video about the birthing unit at Bournemouth and provided research evidence to help women make their choices about their preferred place of birth.

Across Dorset, there was a Dorset-wide labour line, operated out of normal hours by midwives. Midwives ensured women were advised of this service and how to use if they thought they were in labour or needed advice. There was information on the front of their notes to guide women to access the Dorset Maternity Labour line.

**Meeting people’s individual needs**

The service took account of women’s individual needs and preferences.
Through the Better Births initiative, the service had set up a single point of access for women to find out about local birthing services, view videos and consider their own risk factors and birth preferences in planning their birth options. This website was continuing to be developed and was supported by the trust.

Maternity services had access to interpreting via a telephone service. For bookings, staff used face-to-face interpreters and we saw notes of a high-risk complex case where an interpreter was present for the antenatal consultant appointments.

The maternity care assistants had access to the Baby Friendly Initiative (UNICEF) Translation sheets when providing feeding advice to women.

All community staff had smartphones and could use translation apps if necessary to help with explanations. The service also employed a midwife who could use sign language.

The midwives in the Sunshine team had close links with social services, health visitors and other groups supporting women with individual needs. For example, they supported women who been trafficked, working women, women leaving care and teenage groups. The midwives met with women at the children’s centres, at their homes or in the clinics.

The trust told us a member of the Sunshine team who supported the trafficked women and refugees worked closely with a local project specifically for this group of women. They had set up links with local maternity support partners to provide additional support for these vulnerable women.

Midwives identified women with mental health needs through the screening undertaken at booking and at each antenatal appointment. They referred individuals with moderate to severe mental illness to the Sunshine team who liaised with specialist disciplinary teams in the antenatal clinic, community and postnataally to the local mother and baby unit.

We spoke with two women for whom English was not their first language. They said staff had provided clear and through explanations of what to consider and what to expect at the antenatal clinic.

Aromatherapy was available for all women in labour as a complimentary therapy to aid relaxation in labour.

**Access and flow**

Women could access maternity services when they needed it, with access to 24/7 telephone guidance and prompt responses.

Women and partners were able to book onto the weekly evening antenatal courses using a phone booking line or via an online link on the hospital website. Staff said they put on additional sessions if there was high demand. The service also offered ‘meet the midwives’ sessions, as informal, drop in sessions for women and partners wishing to meet the birth team in the birthing unit.

Midwives said they had an improved process for ensuring they booked women for their first antenatal visit within 10 weeks. Women attended for their scan and staff carried out blood tests at the booking appointment. Women had opportunities to meet the consultants if assessments suggested this was necessary.

One women told us how they had reported concerns with their pregnancy by phone and a midwife had attended in less than an hour to initiate checks. They had also seen the consultant promptly.
Two other women commented on a fast response from midwives and they said they knew how to contact the service for advice.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons where appropriate. The service shared lessons learned with all staff.

The head of midwifery had sight of all complaints and assigned them to the relevant medical staff or clinical lead for further investigation.

Staff recognised when women needed additional support and were not happy with their care. We reviewed a case where a woman had expressed concern about her care and treatment. We observed their medical history was complex and they were assessed as high risk. Records showed that staff listened to her views and provided appropriate physical and emotional support, which resulted in the woman writing a letter of thanks and appreciation to the service.

The trust data showed there had been no complaints relating to maternity in the period August 2017 to January 2018.

**Is the service well-led?**

**Leadership**

Managers throughout the service had the right skills and abilities to run the service and provide high quality sustainable care.

Staff at all levels reported effective and responsive leadership of the service, and said that leadership had improved significantly in the past two years. The head of midwifery said they received good support from the executive team and the divisional operational and clinical leads. The head of midwifery reported professionally to the director of nursing and midwifery and managerially to the divisional head of nursing. They said they had been encouraged and supported to make positive changes to the service. The director of nursing and midwifery was the board level champion for maternity services.

There was strong local leadership of maternity services. Staff and managers were also positive about the leadership skills of the head of midwifery. Their feedback was that they provided ‘fantastic leadership’ and this had helped improved teamwork and a more positive attitude amongst all staff. Staff commented on how leadership had improved in the past two years, with two midwives saying, it was 'like a different hospital' with ‘great working relationships’ and a shared understanding of risk and of where to make improvements.

The service had appointed staff to leadership roles. For example, there were two appointed smoking cessation leads, and leads for education, clinical risk, safeguarding, screening and antenatal care. There was a strong cohort of clinical leaders, including the two clinical leads for community services and the lead for the maternity unit. The maternity care assistants also took on specialist roles, such as breast feeding.

Staff said the executive team were visible and supportive. They had issued regular updates on the clinical services review and had joined staff for the midwifery service ‘away days.’

There was an overall view amongst staff that directorate leads were committed to managing risks and to learning from incidents. Staff also said there was improved teamwork amongst the
consultant body, which has helped develop shared protocols and learning. Their regular Monday huddle, had helped the service identify risks.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn the vision into action. This was developed with involvement from staff, partners in service delivery and women who used the service.

Staff spoke about the trust's vision to work in partnership and continually improve services. The trust objectives were, broadly, to support staff, deliver continuous quality improvement, reduce harm, strengthen team working and listen to patients. There was evidence of these objectives being achieved within maternity services.

The pan Dorset maternity strategy 2014-19 set out the direction and priorities for maternity services across the area. The strategy outlined the context of maternity services nationally and emphasised the principles of normalising birth, with safe, caring clinical care provision. The strategy made reference to local demographics and the Dorset commissioners were leading the strategy implementation.

The trust aimed to integrate its strategy with the nearby trust, through the implementation of the clinical services review of the Dorset health economy.

The service monitored outcomes in relation to staff satisfaction, the quality of service delivery through audits, patient satisfaction and data on safety and access.

**Culture**

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

The staff survey in 2017 identified where improvements were required. These related to the time taken to fill vacancies, including those relating to maternity leave, and caseload review. They also related to the lack of satisfaction with amount of responsibility given, satisfaction with opportunities to use skills and the value of appraisals. Following this survey, the service had implemented a range of changes to improve staff satisfaction. These included improving recruitment and succession planning, creating additional senior roles, allocating roles of responsibility to staff and setting up the 'Caring for You' clinics. The service was also facilitating more joint working with the neighbouring trust, through setting up honorary contracts, and senior staff had revised the appraisal process. The service away day and newsletters had also helped to celebrate staff contributions.

All the staff we spoke with said the culture of the service had improved significantly and said there was a strong culture of working together and supporting each other as well as providing high quality care for women. In the past year, staff had actively promoted an improvement in staff wellbeing through a range of initiatives. These had led to the service had been shortlisted for the Royal College of Midwives (RCM) ‘Caring for You’ award. The monthly workshops with the RCM representative meant they were maintaining the opportunities for staff to raise suggestions for improvement.
Staff said they ‘loved working here’ and said it was friendly and supportive, and they were comfortable to ask questions. They commented they had raised issues, such as the lack of space in different parts of the service, and were proud the trust had taken action as a result.

Staff had attended Away Days for team building, which included all staff including domestic staff, operations managers and consultants. Staff also had access to a wide range of staff groups for wellbeing, such as sport, support and health related groups. They could also access groups set up for the diverse needs and interests of the staff population, including faith groups. Staff said they felt valued and appreciated, and welcomed the new equipment such as the smart phones and new laptops.

Staff were aware of the Freedom to Speak up Guardian and said they would be confident to raise issues of concern if necessary. They commented on improved teamwork across management, medical and midwifery staff, to share concerns and ideas. Staff told us this had broken down an historical hierarchy and meant the governance lead had greater insight into risks at all levels.

**Governance**

The service had a systematic approach to improving the quality and safeguarding high standards of care. It created an environment in which excellence in clinical care could flourish.

There were regular staff meetings and newsletters to ensure information and updates were cascaded up and down through the service. There were standard agendas for risk meetings and the minutes were distributed promptly. The trust was reviewing the agenda for risk meetings, as part of trust wide initiative, to raise the quality of the meetings and standardise the type of topics discussed.

Managers and staff recognised that structures needed to put in place to facilitate joint working across trust. For example, the service was working towards running newborn and infant physical examination (NIPE) clinics jointly with the midwives from the neighbouring trust, and was checking the governance and coding implications.

**Management of risk, issues and performance**

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

There was a structured process for reviewing risks. The service held both open and closed risk meetings, alternating these fortnightly. Participants at the open risk meeting included the care group risk lead, audit lead, care group head of nursing and governance lead. The service had started to rota midwifery staff to attend these meetings, for their own learning and development. Regular agenda items included incidents. The closed risk meeting focused more on medical and practice issues.

The trust risk register was reviewed in December 2017 and included seven risks which related to maternity. There was evidence these were regularly reviewed and mitigations put in place. For example, the risk from delays in ambulance transport had been removed from the register following regional-wide discussions with the ambulance service, which had resulted in improved response times. Managers had a good understanding of service risks and what items were on the risk register. The care group head of nursing and the head of midwifery attended the quality and risk committee (QARC), and shared the Top 10 learning points through the open risk meeting.
The service clinical leaders, including the lead consultant for risk, reviewed all learning event report notification (LERN) forms, which had been reported by staff on the incident reporting system. They identified areas for learning and sharing to improve practices. The care group head of nursing also tabled specific incidents for discussion, reviewing notes in depth. The trust introduced the LERN forms in February 2017, under the Share to Care initiative, replacing adverse incident reporting. They were developed for staff to report when something has gone well, as well as to report incidents or concerns, or to suggest an improvement.

The trust planned to further revise the incident reporting process, to give more granularity to the incident type, to help staff record incident types more accurately and share potential triggers more effectively.

The obstetric consultants joined with those from the neighbouring trust for the monthly morbidity and mortality meetings to review stillbirths and neonatal deaths. There had been no deaths within the trust, but this gave staff the opportunity to learn from incidents at the obstetric unit.

The head of maternity viewed all complaints and then referred them to the relevant clinical lead or obstetrician for consideration and completion.

The service organised recruitment promptly, to reduce the risks associated with staff vacancies. Staff also reported effective succession planning and support for personal development.

The service reported on aspects of maternity performance and the Friends and Family results were tracked on the monthly Friends and Family score. Other performance indicators included incidents (such as transfers of care), compliance with mandatory training, and the timeliness of assessments.

Maternity services carried out a programme of audits, supported by the trust’s audit department. There was evidence of actions taken in response to audits and staff undertaking re-audits to check on progress.

**Information management**

The service collected, analysed, managed and used information well to support its activities. It used a secure electronic system as well as paper records.

The maternity service collected data on screening activity, continuity of care, birth numbers, transfer numbers and outcomes. Staff were aware of the performance trends through the newsletters and from minutes of meetings.

The service reported to commissioners on their booking and delivery numbers and presented their performance data to the trust health assurance group annually, and by exception at other times.

Bournemouth maternity services used the same IT system as the maternity services in the nearby trust, which enabled them to access details about women who received their care across both sites. This pathway meant there was continuity between the two trusts with regards to recording and accessing information and care plans.

Community midwives had smartphones and access to laptops to improve real time bookings and information sharing. This also enabled them to view ultrasound scans in community clinics, which was of benefit to both staff and women. The system was also used by midwives from the obstetric unit, which supported sharing of information for safer and higher quality care. The IT system supported effective MDT, since maternity staff could access blood test results throughout the county.

The trust submitted reports on incidents to national external agencies to support wider learning. After a confidential personal information breach, the service shared lessons learnt across the trust.
Engagement

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

Two midwives from the service had been shortlisted for the 2018 Royal College of Midwives Annual Midwifery ‘Caring for You’ Award. This was for their work since 2017 to improve staff wellbeing, under the ‘Caring for You’ charter. The group had set up regular ‘clinics’ for staff to identify improvements to their working lives. A key outcome from this had been the change in shift patterns. The group had also secured smart phones for staff, which meant they could access emails more easily and women could contact them for advice more easily. In addition, under Caring for You, the team secured new jackets for staff, an annual away day, study days for maternity care assistants, and changes to the staff facilities at the birthing unit. A poster describing this achievement was on display on the birthing unit.

They had been good engagement with women as a result of the ‘Better Births initiative. The commissioners had won the bid to deliver this initiative at the three trusts in Dorset. As a result, the trust had been part of various events to find out what birth facilities women wanted in the county and to identify gaps in services. This included meeting with women in children’s centres and playgroups. The engagement activities had led to the identification of women’s priorities for good care. The service had allocated a clinical lead who had dedicated time to work on the initiative to improve services locally.

The service reported that feedback from women showed they were not familiar with the location and facilities available at the birth centre. As a result, staff had created an additional clinical room at the centre, which could be used for clinics, as well as set up a series of ‘meet the team’ sessions where women and their partners could meet midwives informally in centre.

Staff at the birth centre provided antenatal and postnatal clinics, and received a comment that there were no baby changing facilities on site. As a result the clinical lead worked with the estates department to provide baby changing facilities.

The service produced a monthly newsletter, which highlighted training opportunities, performance updates and learning from incidents following the risk meetings.

Midwives encouraged women to complete Friends and Family feedback cards, to identify areas for potential improvement and to celebrate and share positive comments.

Learning, continuous improvement and innovation

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

Staff were encouraged to make suggestions to improve services and the service formally commended them for their work. The trust used a formal improvement methodology and maternity services had applied this approach to review and improve the antenatal pathway of care, reducing the number of sample errors.

There had been a serious incident within the service in the last 12 months that related to information security. As a result of this incident, the service had stopped sending information by fax and used encrypted email communication instead. The service had issued a ‘synopsis of key learning from serious incidents report for wider distribution within the trust for shared learning. The one-page document summarised the context, contributory factors and action the trust was taken to reduce the likelihood of a repeat.
The service had appointed a new practice development midwife to support staff training. They had analysed the education and training needs of the staff group, and set up the skills and drills sessions. Staff said this type of training was very useful and accessible. At our last inspection we had identified a lack of protocol for an emergency evacuation of a birthing pool at the unit. This time, we found that policies and procedures were in place and staff had created a video to demonstrate how to evacuate the pool safely and there had been drills. This shows there had been learning from the previous inspection findings.

The trust had held an annual safety and conference in September 2017, for all staff, as part of their quality improvement programme. This was used to share staff-led improvement initiatives.

The unit displayed important information for staff learning on the staff notice board. This included the monthly newsletters, reports from the quality and risk governance meetings and the results of perinatal mortality surveillance review. It also displayed reminders such as the prompt to record carbon monoxide levels on all women at 36 weeks. Staff received prompts via the trust’s ‘Green Brain’ webpage, when they needed to complete role-specific training updates.