University Hospitals Dorset NHS Foundation Trust

The Royal Bournemouth Hospital

Inspection report

Castle Lane East
Bournemouth
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Tel:

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Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at The Royal Bournemouth Hospital

Inspected but not rated

University Hospitals Dorset NHS Foundation Trust provides acute and emergency services to people living in Poole, Bournemouth and East Dorset. University Hospitals Dorset NHS Foundation Trust provides a wide range of hospital and community-based care to a population of 771,000 based in the Dorset, New Forest and south Wiltshire areas.

On 1 October 2020, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust merged to form a new organisation.

The trust provides a wide range of hospital and community-based care; and employs approximately 8,400 members of staff, both clinical and non-clinical. The trust has not been rated since the merger in October 2020. The hospital's ratings were inherited from the previous provider.

We carried out a focused inspection with a short notice on 27 and 28 June 2023. The inspection was carried out because we had concerns about care and treatment in some areas of urgent and emergency care. We did not look at all key lines of enquiry but limited these to areas where concerns had been raised.

Urgent and emergency services

Inspected but not rated

- The service had enough staff to care for patients and keep them safe most of the time, although the skill mix and experience was not always optimal. Leaders did their best to cover unplanned absence and balance the skill mix and maintain frequent and tailored high-quality training for all clinical staff.
- Staff had the skills and knowledge to protect patients from abuse and acted when it was necessary. The service mostly controlled infection risk well but we observed some lapses from staff in meeting trust policy around dress code and management of their personal protective equipment. There was effective cleaning and we saw a visibly clean and well-organised department.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. Teamwork was exceptional and highly valued by all staff. However, given the issues with demand and capacity, patients having growing health and care needs, including mental health, and growing demand for the service, staff morale was hard to maintain.

However,

- There were long-standing national issues with access and flow through the whole health and care pathway. The south west of England was no different, and coastal towns such as Bournemouth had been overwhelmed with patients and a lack of capacity for many months, including a very difficult winter period.
- Patients' records were not always completed sufficiently well, for longer-stay patients particularly, to demonstrate staff met care needs, assessed risks to patients and acted on them.
- We were concerned that some of the standards of nursing care fell short of preserving and maintaining the privacy and dignity of patients at all times.
- Some of the practices for caring for patients needing to remain in the department for extended periods of time gave rise to possible risks; including the use of canvas stretchers and patients left lying in a shearing position.
- Although urgently addressed at the time, there were issues with the practice for labelling patient samples which did not meet trust policy.
- There was a lack of some patient visibility for the staff responsible for the safety of the department and the reception area was not always suitable for people using wheelchairs to do so safely.

Is the service safe?

Inspected but not rated

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. They could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They described well how they would identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns.

Urgent and emergency services

There had been an increase in patients leaving the department due to long waits for treatments. A process of alerting children's services if parents or carers left the department before their child had been seen had been implemented. This ensured the welfare of the child was assessed and to encourage parents and carers to return to the department with their child.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well but we observed some lapses from staff in meeting trust policy around dress code. Staff used equipment and control measures to protect patients, themselves and others from infection, although we saw lapses from some staff in the management of personal protective equipment. They kept equipment and the premises visibly clean.

All areas, including those at height, were visibly clean and had suitable furnishings which were clean and well-maintained. Most of the furniture such as beds, chairs, and mattresses were in good condition to allow for effective cleaning and all the curtains appeared in good condition, were disposable, and dates showed regularly changed.

Staff mostly followed infection control principles. We saw mostly good adherence from staff to hand washing and infection control procedures. However, we did see some staff wearing gloves during more than one interaction with patients. Some staff were wearing gloves without removing and replacing them when required by trust policy. Most washed their hands or used alcohol gel before and after any interactions with patients or when entering or leaving the department, but we observed this policy had become lax with some staff. We did notice patients and visitors not actively using the hand gel provided or being encouraged to do so either in the waiting area or moving into the treatment/triage areas. Compliance with the hand hygiene audit in April 2023 was 80%. Senior hospital leaders explained the process of aligning quality audit processes across the trust meant new metrics were being used at the hospital which required time to be embedded. Compliance with this audit rose to 84% in May 2023.

There were cleaning staff working throughout the department during our visit. The areas we checked were clean and free from dust. We observed staff cleaning equipment after patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe.

The main patient waiting area in A&E was of a reasonable size to accommodate people, and had safe and well-maintained fixtures and fittings. It was light and spacious with toilets for visitors and a vending machine. However, there were problems with clear visibility of all patients. The room was mostly square, but the walled entrance area built into the waiting room blocked visibility for the reception team of those patients who sat around the side of the entrance. On our visit we observed how many patients seemed to prefer this area as it gave a view to outside from the windows. Although there was live feed from cameras of the waiting area, including the area obscured from reception, the screens with the images were in the rapid assessment area and not the reception area. We spent some time observing if the screens were watched from the rapid assessment area, but did not see this happening with any regularity. However, with the unit relocating in 2024/2025 to a new emergency department on the site, there were no plans to reconfigure the department.

We were concerned with how the reception facilities were not fully accessible and suitable for meeting and talking with people who used wheelchairs. We observed how at times this made hearing and talking with staff at the reception desk (who were behind clear safety screens) unsafe for patients some of whom were trying to stand from a wheelchair to do this. This was not an issue with the adjacent nurse streaming service where the desk was at a low height designed for wheelchair users.

Urgent and emergency services

While we were talking with staff in the reception area, three patients arrived who were unwell and having trouble standing. At that time there were no wheelchairs anywhere to quickly provide for those patients. Staff ended up touring the department to locate them. We were told the availability of wheelchairs was a "lottery" and mostly they were located at the Urgent Treatment Centre where patients were often redirected. Staff said they were not aware of a system for bringing them back or making sure the emergency department always had them available.

The hospital standard wheelchairs were also, we found, hard to manoeuvre. We assisted a patient and their friend to get to the urgent treatment centre, located along an outside pathway in the next part of the building. This proved tricky and the chair was heavy and hard work. The friend was recommended to pull it backwards by staff, but this added its own risk from them tripping or falling. We were concerned as to how any frail or elderly people would have managed to make this journey with a patient. Our other concern about reception was whether the patient experience had been considered with there being two touchpoints when booking in at reception. The patient was first met by the streaming nurse, but then had to attend the next window to give more information to the reception staff. Although we could see the clinical expediency in this arrangement, we could also see the frustration or confusion for the patient or relative/friend, particularly those who were feeling unwell.

There was a lack of some equipment needed to carry out examinations on patients. We saw staff looking for stethoscopes and pen torches and not being able to find any. Although staff recognised this issue and those listed above as risks to patient safety they were not reflected in the department's risk register.

We observed the handling of patient samples (blood taken and stored in small bottles for analysis in this instance) did not always meet trust policy and procedure. Although urgently addressed at the time, there were issues with the practice for labelling patient samples which did not meet trust policy. For example, we saw blood request forms being printed after blood had been taken, samples being taken away from the patients' bedside to be labelled, and samples given to colleagues to label. This issue was on the departments risk register. The risk register identified that if staff do not follow the policy for patient identification and labelling of samples this may result in delays in patient care.

Compliance with environmental checks was 39% in April 2023. Senior hospital leaders explained the process of aligning quality audit processes across the trust meant new metrics were being used at the hospital which required time to be embedded. The compliance with these checks rose to 81% in May 2023.

Ambulance crews had direct access to the department and their own entrance. The hospital had a helicopter landing area located immediately outside of the department and we were told well-rehearsed safety procedures would be commenced to safeguard everyone in the vicinity when a landing was being made.

The trust met the environmental recommendations from the Royal College of Paediatrics and Child Health Standard for Children in Emergency Care Settings in having specific areas for children. However, the waiting area was small and not as child-friendly as it could have been, but we were told there were plans to improve the décor with some new wall-paintings. The emergency department also had a specific treatment area for children although with children having to access their treatment area through the department. Children were therefore not always protected or removed from seeing and hearing adult patients, some with complex needs.

The triage room located within the waiting area provided patients with privacy and confidentiality from other patients. The doors into the rest of the department were locked with swipe card access for authorised personnel.

Urgent and emergency services

The resuscitation area had three bays, one able to accommodate a child, and was well stocked with the required equipment, including that for children, pregnancy complications, and other specialist areas of treatment. We were told the bays could get full in times of high demand, but a three-bedded area was not untypical provision for a department of its size.

Clinical waste was disposed of carefully and those bins we saw for the disposal of sharp instruments were not overfull, although some were a little far away from the treatment area, specifically in majors. General waste bins were being regularly emptied by the cleaning staff.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, the provision of longer-term care for patients who were delayed in being handed over for further treatment was not well documented or described. Not all patients were given the optimum equipment for risks from skin damage.

Staff were aware when a patient was assessed at risk from falls, pressure ulcers or other potential unintended harms. Risk assessments were being completed and a flag raised to alert staff on the electronic patient record. Pressure relieving and falls prevention equipment was being used when indicated. However, we were told, with the advice of the moving and handling team, patients brought in by ambulance were left on stretcher canvasses for the duration of their A&E stay to make their onwards transfer to a ward less onerous for staff. Stretchers or patient trolleys are designed to be compact and are easier to manoeuvre than a hospital bed, they also offer close access to the patient for examination and emergency care. However, the mattresses are generally thinner, so less comfortable and suitable for short periods. We saw 2 patients who were resting on stretcher canvasses in a shearing position. Shearing refers to skin tissues being moved in the opposite direction to internal body structures which may lead to deep tissue injury. The hard stretcher canvas is more likely to cause shearing than a softer surface. One of the patients we observed in a shearing position was left for over 90 minutes without being repositioned despite the concerns we raised with the nursing team.

Staff used the National Early Warning Score (version 2 – NEWS2) for adults and children over the age of 12 patients and the Paediatric Early Warning Score (PEWS) for babies and children under the age of 12. Those records we saw were all completed. We reviewed 3 records of NEWS scores and found the assessment of the patient and subsequent scoring to be in line with guidance. Patients who were registering a high NEWS score had regular reviews and updates, and had been flagged for medical review as required.

The emergency physician in charge and nurse in charge had regular structured meetings throughout the day to monitor the activity in the department. They used an electronic monitoring tool for oversight of the patients which included NEWS and PEWS score and time spent in the department. They discussed every patient and reviewed progress of plans to reduce risk. If the number of patients in the department was reaching capacity, they could escalate the situation to senior hospital leaders. Once in escalation, staff from outside the department were asked to increase their efforts to enable the transfer of patients who were well enough, out of A&E and onto a ward, hospital leaders could also move staff from other areas of the hospital to increase staffing levels.

We were concerned about the documentation of needs of those patients who were remaining in the department for longer periods of time, than would be typical for an emergency department and clinical team. There was no structured extended care plan in use which gave clear evidence of the management of patients' longer term medical and nursing

needs. This included, for example, showing early recognition of time-critical medicines, regular repositioning for skin integrity, and assurance of hydration and nutrition needs being met. We did not see these needs going unmet, but the structured documentation which could be audited and checked for compliance and assurance for the department leaders was not evident.

The senior nursing team carried out a monthly audit of the environment. The audit carried out in June 2023 was compliant with all aspects of the patient experience. Of the 5 patient experiences that were included, all had their call bell within reach and the only patient that was not nil by mouth had a water jug on their table. All patients had their pain adequately controlled.

The assessment of patients who were brought into the department by ambulance or identified as acutely unwell on arrival was carried out by a clinical team in the rapid assessment area. There were separate bays in the unit set aside for ambulance arrivals with higher levels of equipment and a full team of clinical staff to assess the patient. This early assessment enabled rapid diagnostic tests to be arranged, risks to be identified and requests made for any speciality input.

One of the key members of the wider team for keeping patients safe was the hospital ambulance liaison officer, or 'HALO'. This was a paramedic employed by the NHS ambulance service and on duty at certain planned times of probable capacity escalation. The HALO reported a good working relationship with the emergency department team and well-managed prioritisation of the sicker patients. They were based with the team in the rapid assessment unit and able to quickly respond to the need for escalation or clinical diverting of patients.

We observed how the system for urgently contacting clinical staff was sometimes not working effectively. There was a need at one point for clinical staff to assess a situation quite urgently with a patient (this was not a significant medical emergency, such as cardiac arrest, when there was an effective process). The phone call from the streaming nurse in reception to the rapid assessment team went unanswered (as they were likely to be busy with other patients). We understood there was a system for the rapid assessment team, the ambulatory care team and the nurse in charge to rapidly communicate with each other, for example, but this did not extend to the reception team. We reported this to the leadership team to look for a possible solution.

Staff referred children and adult patients experiencing mental health problems to mental health teams based within the hospital. However, staff told us patients sometimes needed to wait a long time to be seen by these teams especially overnight and at the weekend and especially for the Child and Adolescent Mental Health Services (CAMHS).

The department was not designated to provide emergency treatment to children. This service was delivered by Poole Hospital and the ambulance service conveyed all children and young people there. For children who attended the department there was a process to ensure they were conveyed by emergency ambulance to Poole Hospital if they required emergency treatment. In the 12 months before our inspection 581 children had been transferred, 561 to Poole Hospital, 5 to the A&E department in Salisbury and 15 to the A&E department in Southampton.

Nurse/paramedic staffing

The service maintained enough nursing/paramedic staff and support staff at most times with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Urgent and emergency services

There had been improvements in the number of nursing staff in the department with the recruitment of new nursing staff, including international nurses. However, senior departmental nursing staff were honest and open that this meant the workforce did not yet have the skill mix and experience required to be fully efficient at all times. As a result, an increased and improved learning and development programme had been brought in to support staff in embedding and improving their skills and experience. This involved embedded practice educators, who were experienced nurses whose role was to train, educate and improve skills through various options including bedside teaching. We recognised, as did the department, this would take time to be fully realised.

International nurses joining the department had a three-day induction and were linked with a band 6 mentor to support them. The department had its own practice educators who were closely linked with the international nurses. The practice educators worked with the practice education team across the trust to share themes and areas for further development for international nurses. The nurses studied all the main clinical competencies and were evaluated on progress.

International nurses were provided with mental health and practical support, and pastoral care if needed. A trust team in the HR department provided support entirely for international staff. There was a new programme of enhanced learning for band 5 nurses from a minority background to progress to band 6 roles.

There continued to be regular use of agency nursing staff for unplanned and other absence. Many were regular workers for the department.

Medical staffing

The service maintained enough medical staff at most times with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Senior leaders told us they did not have enough consultants to meet the guidelines recommended by the Royal College for Emergency Medicines and the Royal College of Paediatrics and Child Health for the size of the department and some shifts were not fully covered. To mitigate the risk, doctors from other areas of the hospital were sometimes used, and Emergency Department consultants worked cross site between Poole and Bournemouth Hospitals when required. The recruitment of doctors had sometimes been difficult, which followed a national trend, the trust had invested in employing Advanced Clinical Practitioners (ACPs) and Physician Associates (PAs) to mitigate this. ACPs are health care professionals that have undertaken additional training to allow them to assess, diagnose, and treat patients including prescribing medication and referring on to other services. PAs undertake training equivalent to a junior doctor and perform a similar role to ACPs but are unable to prescribe or order radiological investigations at present. The ACPs and PAs were well managed in terms of oversight and skill mix. The trust had innovative recruitment plans for overseas clinicians with a strong culture around settling in international medical graduates including funding degrees to improve recruitment and retention of medical staff. A business case had also been submitted to obtain funding to employ a larger number of junior doctors and ACPs to support the clinical workforce both in and out of hours.

Junior doctors, ACPs and PAs told us consultants were approachable and supportive and could be relied on to offer advice on medical and non-medical issues, for example identifying a safeguarding concern.

Records

Staff mostly kept detailed records of patients' care and treatment, but had no clear consistent record to show how extended care was being safely provided.

Urgent and emergency services

The department used a combination of electronic notes and some reducing numbers of paper documents for recording patient care and treatment. A new electronic notes system was about to be introduced, in preparation for this staff were receiving training on the new system.

We reviewed 10 sets of patients records, which did not consistently contain a record of intentional rounding. Intentional rounding, often referred to as rounding, is a process used by nursing staff to carry out regular checks, usually hourly, with patients using a standardised protocol. Rounding addresses issues of positioning, pain, personal needs, and placement of items, in an emergency department it might also include an assessment of patients' psychological wellbeing and a review of their time critical medicines.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, but there were a couple of lapses of respect for privacy and dignity. Staff did take account of people's individual needs, but the lack of wheelchairs and the difficult journey to the urgent treatment centre for frail patients or carers had not been considered in terms of patient experience.

Staff were kind and caring with patients and families. This included staff across the department in different roles. We met a number of patients and their families and all of them were happy with the care and compassion they had received. We observed and overheard staff talking warmly with patients and relatives and reassuring them. This was particularly evident in the interactions in the ambulatory care unit and the Majors B area. Here, most patients were all able to stay in rooms rather than all cubicles and this appeared to prompt staff to regularly check on them as they were not immediately visible.

We observed staff giving as much time to the patient and any family as possible. They came across as non-judgemental and respected people's rights to make their own choices, even when they were not in their perceived best interests.

However, we were concerned about a small number of lapses in respect for people's privacy and dignity. We observed two patients, one in Majors A and the other in the observation area, who were either fully exposed or from the waist downwards. None of the staff in the immediate area had noticed this and a number had walked past without observing this or helping the patient. One patient was clearly confused but did not have sufficient support to keep them safe and maintain their dignity. We sat within the Majors A area for some time and at the time, when the department did not feel overwhelmed and was well staffed, observed a group of quite vulnerable patients. We observed how they had insufficient nursing attention in terms of their risks and dignity while nevertheless a large group of staff were based at the end of the area working at computers and desks.

There was also an issue for a relative of a patient who had arrived separately by ambulance, but, it transpired, had been taken elsewhere in the hospital for tests and not booked in at the emergency department. This was the correct clinical pathway in this situation, but the reception staff had not been trained to know of this potential diversion of the patient. This caused significant anxiety to the relative when being informed their whereabouts of the patient was unknown. We fed this back to the senior team at the time in order for them to consider the system used in this circumstance and if it could be improved.

Urgent and emergency services

Is the service responsive?

Inspected but not rated

Access and flow

Alongside and as a result of long-standing local and national issues in the whole health and care pathway, people could not always access the service when they needed it and receive the right care promptly. Waiting time standards, handover times from ambulance crews, and time spent in the department were frequently missing national standards or comparable results.

There were long-standing local and national issues with access and flow through the whole health and care pathway. The south west of England and many coastal towns such as Bournemouth had been overwhelmed with patients and a lack of capacity for many months. This was not restricted to the predicted higher activity in winter, but extended throughout the year including the height of the summer holiday period. As a result, the hospital was frequently unable to take patients from the emergency department to a ward bed at the time the patient was assessed and ready to be handed over for further care and treatment.

Subsequently, not all patients could get access to the service in a timely and clinically safe way, and some were remaining in the department for longer than was clinically or psychologically optimal. There had been lengthy handover delays for ambulance crews and patients known to be waiting longer in the community for care and treatment from the emergency services. This was fully recognised by the trust board and assessed as a high risk on the corporate risk register.

Nevertheless, managers and staff worked hard to make sure patients did not stay longer than they needed to. Patients were prioritised in terms of clinical need and those who were urgent were seen as quickly as possible. There was a clear focus on the departmental dashboard where length of stay and clinical need were clearly indicated and staff were aware of each patient's needs and reasons for any delays.

We observed a meeting where staff from across the hospital discussed capacity with the aim of improving flow. These meetings take place twice every day. At the meeting we saw staff working together to benefit patients waiting to be transferred out of A&E.

Data showed how, along with all NHS emergency departments, the trust was not meeting the national standard for admitting, discharging or transferring 95% of patients within 4 hours of arrival. University Hospitals Dorset NHS FT had been part of an NHS pilot for the last three years, trialling the use of other clinical standards for emergency departments. This trial had recently been ended and the trust reverted to reporting its performance against the 4 hour standard.

The trust's percentage of patients waiting more than four hours from the decision to admit to admission increased (deteriorated) considerably from 24.0% in May 2022 to 39.6% in December 2022. There was then a reduction to 31.7% in March 2023. The trust's performance was considerably better than the England and South West averages until September 2022, but since then its performance has been much closer to the averages. For comparison in March 2023 trust performance was 31.7% compared to the South West average of 33.8%.

There was a considerable increase in the number of the trust's patients waiting more than 12 hours from the decision to admit to admission from 113 in September 2022, to 332 in December. This was followed by a reduction to 185 in March 2023.

Urgent and emergency services

The trust consistently reported a much longer (worse) median time from arrival to treatment compared to the England average from May 2021 to February 2023. There was a considerable reduction from two hours eight minutes in December 2022, to one hour 46 minutes in February 2023, but this was still considerably worse than the England average of one hour eight minutes. The trust's median total time in A&E was consistently longer (worse) than the England average from May 2021 to February 2023. There was a considerable increase from 4 hours 13 minutes in August 2022, to 5 hours 2 minutes in December 2022. This was followed by a reduction to 4 hours 44 minutes in February 2023. However, this was still considerably worse than the England average of 3 hours 4 minutes.

However, the department saw a reduction (improvement) in the percentage of ambulance handovers taking more than 60 minutes from 48.8% in December 2022 to 10.3% in May 2023. This coincided with an overall improvement for the regional ambulance service, South West Ambulance Service.

We saw information that showed the trust has improved its performance in all of the above metrics in the three months before we inspected. In addition, it is important to give the metrics context and point out that A&E attendances at the trust were higher than 60% of other hospitals in the country and there were more patients being treated by the trust than most other trusts in the country.

Is the service well-led?

Inspected but not rated

Leadership

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

University Hospitals Dorset (UHD) NHS FT ran two emergency departments in Dorset, this one located in Bournemouth and another located at Poole Hospital. UHD was a merger of two existing NHS trusts in south Dorset in 2020. Since that time, the emergency departments had been joining their senior teams together to gradually share leadership and resources and develop mutual systems and processes.

Staff told us they felt well supported by their senior team. They said they were visible and approachable and the department worked well as a strong team. All those we met in the staff team said they felt confident and able to speak up to senior staff and managers. There was a learning culture in the department and effective support for staff to train and develop into more senior roles and learn new skills.

A number of staff said they regularly saw the trust leadership in the department and felt supported by the executive team particularly when the department was in extreme escalation. However, other staff felt the trust leadership team were not visible. They said things like A&E had been "abandoned" and "forgotten" by trust leaders and previously when the department was in escalation trust leaders would have been visible and asking what they could do to help.

Culture

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

Urgent and emergency services

Staff in the department felt valued by one another. We observed staff working well together, knew each other well, and were supportive and kind. This extended to teamwork with other services and specifically the NHS ambulance service where staff reported good working relationships.

The senior leadership team told us how they were most proud of the emergency department team and how they had been incredible to work with, with great tenacity and enthusiasm despite the challenges faced. They were also proud of the training offered and how that had developed over time with the practice educators to be an effective and valued service.

There was a principle embedded in the department of the need to mentor, support and train new staff, and to provide them with confidence and grow their experience.

However, there was a concern we raised with the trust about a number of international staff not recognising the role of the Freedom to Speak Up Guardian. We recognised staff had possibly been overwhelmed with new information on joining the trust, and there was a lot to learn. This role is a UK national role which is not as universally recognised as other healthcare jobs (and might have other names in other countries). It could have been well explained and introduced, but had not been well understood. However, staff from minority backgrounds did tell us they had both formal and informal networks and were not concerned about speaking up to their own managers or colleagues.

We asked staff about a number of issues we had found, such as wheelchairs not being available, staff not being able to find a patient for a relative, and an internal call for assistance going unanswered. We asked staff if these would be reported as incidents, and they were honest in admitting they probably would not be. One member of staff said, “they are somewhat normal life.”

The annual NHS staff survey for the trust (which was not broken down by separate departments) which took place between October and November 2022 uses a scores range from 1 to 10 – a higher score indicates a better result. The results showed the trust scored below the average for three elements: ‘We are Safe and healthy’ (5.8), ‘We are always learning’ (5.3) and ‘Morale’ (5.6). Three elements were above the average ‘We are compassionate and inclusive’ (7.3), ‘We each have a voice that counts’ (6.7) and ‘We are a team’ (6.7). We are recognised and rewarded’ reduced from 5.9 to 5.7 and ‘We each have a voice that counts’ deteriorated from 6.8 to 6.7.

Nearly three quarters of staff (73.6%) at the trust said they would feel secure raising concerns about unsafe clinical practice which is better than the national average of 70.7%. Just over one in five staff (21.2%) believe the provider is adequately staffed, worse than the national average of 25.5%.

The Workforce Disability Equality Standard (WDES) is a set of measures which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The trusts WDES results for staff with a long-term condition or illness were notably different to results for staff without a long-term condition or illness at the trust, indicating poorer experiences for staff with long-term conditions or illnesses. These results were consistent with the national response to these measures.

The Workforce Race Equality Standard is a set of measures which enable NHS organisations to compare the workplace and career experiences of staff from ethnic minority groups with their white colleagues. The results for the trust show that a much higher proportion of staff from all other ethnic groups had experienced harassment, bullying or abuse and discrimination from managers or other staff in the previous 12 months, than their white colleagues. They also had less belief that their organisation provided equal opportunities for career progression, indicating poorer experiences for them.

Urgent and emergency services

We spoke to representatives of the diversity and inclusion network for the trust who told us about initiatives they planned to raise awareness around racial discrimination and to promote inclusivity.

Management of risk, issues and performance

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

The department was aware of its performance, resilience and risk from a local dashboard designed to provide live data throughout the day and night. This was visible to all staff in the department and was used, for example, when one department had less capacity than the other and it might have been beneficial for patients to divert ambulances to the other emergency department.

The department used an internally-designed version of the NHS national 'operational pressures escalation level' (OPEL) framework known as the 'emergency department capacity level tool'. This was refined to use data which took into account other aspects of the hospital's resilience. The leadership team were open and honest about this tool and considered how 'escalation fatigue' (in that the department felt always to be in higher levels of risk and escalation) had meant response to the tool from decision makers had been limited of late.

It should be noted there was no specific knowledge in the local senior team of how the trust's emergency departments were represented with the Integrated Care System or Board.

The risk register did not recognise risks around the delays of provision of clinical support for patients experiencing a mental health crisis. There was little provision of mental health support for out of hours and at night when the department felt this was the most demanding time for patient's needs. However, as a response to recognising the growing need for mental health care, the department was looking at more multidisciplinary work with patients who were regular users of the service or people who were homeless and/or rough sleepers.

During our inspection in 2016, we were concerned that complaints were not always processed within the trust's agreed timescales. The hospital had introduced a process to resolve complaints in collaboration with the Patient Advice and Liaison Service (PALS) within a short time frame. This included having a dedicated PALS officer to contact complainants so whenever possible an early resolution to a complaint could be found. This reduced the amount of complaints requiring a full investigation allowing the trust to process the more complex complaints more quickly.

Areas for improvement

MUSTS

The Royal Bournemouth Hospital Emergency Department

- The trust must ensure the premises and equipment are suitable for purpose. The trust must review the safety of the main waiting area in the emergency department. There was a lack of some patient visibility for the staff responsible for the safety of the department and screens with live feed located elsewhere. The reception area was not suitable for persons using wheelchairs to do so safely. Regulation 15 (1)(c).

Urgent and emergency services

- The trust must ensure it provides safe care and treatment to patients at all times and demonstrate this through clear and complete record keeping for all care interactions. It must demonstrate all patients remaining in the department for what might be considered as an extended stay have all their needs met and these are clearly documented. Regulation 17(2)(c).
- The trust must ensure patients are not left in a shearing position through the regular monitoring and repositioning of patients. Regulation 12(2)(a)(b).
- The trust must ensure staff adhere strictly to policies and procedures when taking and labelling samples from patients. Regulation 12(2)(a)(b).
- The trust must ensure care of patients is given with dignity and respect. The trust must ensure high standards of nursing care are in evidence which include ensuring the privacy and dignity of patients, particularly those who are confused or anxious. Regulation 10(2)(a).

SHOULDS

The Royal Bournemouth Hospital Emergency Department

- The trust should consider the patient experience when requiring them to speak to first the streaming nurse and then the receptionist particularly if the patient is unwell and has to stand for some time at either touch point.
- The trust should look at how to improve communication with relatives when a patient is brought to the emergency department by ambulance but diverted elsewhere for urgent tests and not booked in.
- The trust should consider the patient experience and staff efficiency when there are no wheelchairs available in the department for unwell or unstable patients. It should also consider the hospital wheelchairs being hard to safely manoeuvre for some people. The experience of a child patient and their family or carer should be improved in the waiting area at all times.
- The trust should require all staff to follow infection prevention and control guidance at all times, including the safe use of personal protective equipment and the dress code.
- The trust should consider how to ensure the reception team are able to contact staff for assistance at all times.
- The trust should consider its policy on the use of canvas stretchers for longer stay patients.
- The trust should work closely with the integrated care board to continue to address the significant and serious delays faced by some patients waiting in the department for a hospital bed and remaining in the community as ambulances are delayed in their handover of patients. Access and flow through the hospital and responsiveness to patients was adversely impacted by the pressures throughout health and social care. There should be consideration as to how to manage ‘escalation fatigue’.
- The trust should work with the Freedom to Speak Up Guardian to educate and encourage those staff who did not recognise this role to be an integral part of the otherwise well-respected service.
- The trust should introduce a system that captures all risks facing the department so they can be included on the departmental risk register.

Our inspection team

A team of 1 inspector, 1 CQC senior advisor and 2 independent specialist advisors visited the emergency department and the urgent treatment centre. We spoke with 43 members of staff (including managers, doctors, nurses, healthcare assistants, healthcare professionals, receptionists, administrative staff and a volunteer). We spoke with 5 patients. We reviewed 16 sets of patient notes, we attended 3 meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance