University Hospitals Dorset NHS Foundation Trust

Poole Hospital

Inspection report

Longfleet Road
Poole
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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 Poole 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 and outpatients. 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 a few lapses from staff in meeting trust policy around dress code. There was effective cleaning and infection prevention and control and we saw a visibly clean and well-organised department.
- 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 Poole had been overwhelmed with patients and a lack of capacity for many months, including a very difficult winter period.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. A new patient record system had just been installed and was being rolled-out carefully and adapted to work for the department's needs. 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,

- Patients' records were not always completed sufficiently well, particularly for longer-stay patients, to demonstrate staff met care needs, assessed risks to patients, and acted on them.

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.

We observed the arrival of a frail elderly patient who was clearly vulnerable and with cognitive impairment. They were unkempt and looked unable to care for themselves at that time. Staff were observed being patient and compassionate. Staff said how the safeguarding process had already started and it was recognised they would not be able to return home unless something was arranged to provide them with safe care.

Urgent and emergency services

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well but we observed a few lapses in evidence-based practice from staff. Staff used equipment and control measures to protect patients, themselves and others from infection. 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. Some of the chairs in the waiting room were showing signs of wear and tear and the plastic covers were cracking slightly in places, but otherwise visibly clean.

Staff mostly followed infection control principles. However, we did observe some staff not 'bare below the elbow' to enable safe and effective handwashing or contamination from clothing. In contravention of trust policy, we observed a small number of staff either wearing nail varnish, watches or rings which were not plain bands.

We saw good adherence from staff to hand washing and infection control procedures. Staff were wearing gloves and aprons when it was required for their interactions with patients. Most washed their hands or used alcohol gel before and after any interactions with patients or when entering or leaving the department. We did notice patients and visitors coming into the waiting area were 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. However, we did observe people coming into the assessment area with their relative/friend (called the 'pitstop') being asked to gel their hands on arrival.

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. However, some of the storage areas were small and did not have sufficient room for all the equipment being kept there. This meant some was on the floor (some in boxes) which made effective cleaning of these floors more difficult. In the resuscitation area we noted some chipped paint which could have been easily remedied, but also notices taped to doors with surgical tape, which was against infection prevention and control guidance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. However, there were limited facilities to keep children separate from adult patients when waiting to be seen.

The layout of the department had evolved over many years and as with most older emergency departments, had expanded into other areas of the hospital which made the environment not ideal for safety, visibility, and efficiency. The main patient waiting area in A&E was not big enough for the number of patients waiting at busy times. Staff told us it could fill up easily and patients ended up standing, which could cause obstruction, or waiting outside (although this area was undercover, but was also the ambulance arrival bay). This was recognised by staff as an issue and was on the departments risk register. However, with the unit relocating in 2024/2025 to the Bournemouth hospital major extension and new emergency department, there were no plans to increase the capacity of the waiting area. The area was clean and tidy and there was cold water provided for those waiting, but the machine was out of service.

Live camera feed was provided in the reception area for staff to monitor as reception and streaming staff in the reception area could not see all those waiting due to some areas being obscured. The triage room was small but did provide patients with privacy and confidentiality from other patients in the waiting area. The reception facilities were

accessible and suitable for meeting and talking with people who used wheelchairs. The doors into the rest of the department were locked with swipe card access for authorised personnel. The hospital did not have a helicopter landing area, but helicopters could land in the vicinity and be met by an emergency ambulance crew. The Ambulance crews had direct access to the department and their own entrance.

One area recognised by the trust was the failure to meet some of the guidance for provision of a safe environment for children. The Royal of Paediatric and Child Health Standard for Children in Emergency Care Settings recommends emergency departments have specific areas for children. These include waiting and treatment areas and those for families in a crisis. The emergency department in Poole Hospital did have a specific treatment area for children, but no waiting area. Children also had to access their treatment area through the department. There was a small room in ambulatory care where children and families were sometimes able to wait, but the protocol for use of this room was unclear. When we were in the department it was being used as a form of observation room for adult patients. Children were therefore not protected or removed from seeing and hearing adult patients, some with complex needs.

In order to maximise occupancy in the department for the frequent times of high capacity and demand, the majors bays had patients fairly close together. This made moving a patient's bed quite an artform for the experienced porters, but staff and visitors needing to regularly move out of the way.

The resuscitation area had four 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 four-bedded area was not untypical provision for a department of its size. There had been improvements to the area when it had changed locations, swopping with the children's treatment area, and now had glass doors added to provide improved infection control and privacy and dignity. It was also now located immediately adjacent to the ambulance receiving area and 'pitstop' for rapid assessment.

We observed patients had been given and shown how to use their call bell. The patients we asked said staff had responded quickly to them using their call bell – although most had used them infrequently.

Clinical waste was disposed of carefully and those bins we saw for the disposal of sharp instruments were not overfull. General waste bins were regularly emptied by the cleaning staff.

The department had investment to ensure a safe space for patients with Mental health problems which had been recognised as meeting Psychiatric Liaison Accreditation Network (PLAN) standards set by the national college of psychiatrists. However, staff told us there was a lack of ligature managed rooms for the number of patients with mental health problems seen in the department. Ligature managed rooms are safer spaces for patients experiencing thoughts of ending their lives. This meant patients required higher levels of nursing care than may have been appropriate to meet their physical health needs. This risk was recognised by staff and was on the departments risk register.

To resolve inconsistencies in stock levels staff within the department had developed and embedded a system that used quick response codes (QR codes) for reordering stock of medical consumables. Scanning a QR code enabled stock levels to be counted and included an automated process that emailed the individuals responsible for monitoring and procuring consumables. A QR code is a scannable image that can instantly be read using a smartphone camera. The phone can translate the QR code into something that can be easily understood by humans.

Urgent and emergency services

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.

Staff used a recognised tool to triage patients, this helped them assess how quickly they needed to be seen. The tool included recognising potential sepsis, stroke and heart attack. 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.

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 children under the age of 12. The patient records we saw all had a completed NEWS or PEWS. We reviewed 16 records of NEWS and 6 records of PEWS scores and found the assessment of the patient and subsequent scoring to be in line with guidance. Patients who were registering a high NEWS or PEWS score had regular reviews and updates, and had been flagged for medical review as required. The new electronic patient records system that was being rolled out contained an inbuilt NEWS and PEWS scoring system to assist staff in recognising patients with a high NEWS score.

The emergency physician in charge and the 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 the transfer of patients who were well enough to move 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 found of the 4 patient experiences that were included, none had their call bell within reach and none had a drink or water jug (1 was nil by mouth). However, all the patients had their pain adequately controlled. We were not shown an action plan to address the aspects of the audit that were non-compliant.

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

Urgent and emergency services

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.

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). This was a risk recorded on the departments risk register.

During our inspection in 2016, we were concerned that was inconsistent use of patient identification bands in the department. We saw these risks had been removed by the introduction of an administrative process that ensured patient identification bands were generated as soon as the patient was admitted to majors.

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.

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 nurse-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.

The international nurses were also 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. The service had recently employed a paramedic who told us they felt well supported and found the role a really good opportunity to build stronger relationships being from a different clinical background.

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.

Urgent and emergency services

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. As the recruitment of doctors had sometimes been difficult, which followed a national trend, the trust had invested in employing Advanced Nurse Practitioners (ANPs) and Physician Associates (PAs) to mitigate the risk of not always having enough doctors. ANPs are health care professionals that have undertaken additional training in major presentations (Majors Assisting Practitioners) 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 ANPs but are unable to prescribe or order radiological investigations at present. The ANPs 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 ANPs to support the clinical workforce both in and out of hours.

We overheard senior doctors regularly asking their colleagues if they had taken a recent break and if not, when they might do that. A senior doctor told us they recognised the safety risks with staff not having any time to rest during the day, and this had become harder to monitor when the department was overwhelmed with patients. A couple of staff said they felt guilty taking a break but recognised the advantages of doing so.

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. The system used was primarily electronic and had just been replaced with new software which was still in development to make it optimal for the service.

The department used a combination of electronic notes and a reducing numbers of paper documents for recording patient care and treatment. A new electronic notes system was in use and was being upgraded in real time as staff identified ways in which it could be improved to provide clearer oversight of risks to patients.

We saw 8 sets of patients records that did not record intentional rounding of patients. 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. When we raised this as an issue with the senior leadership team, they said they would ask for the new electronic patient notes system to be modified to include a section to record rounding.

Is the service caring?

Inspected but not rated

Compassionate care

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

Urgent and emergency services

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. This included anxious patients, both adults and children, who were taken through the comprehensive triage process. It also included compassion and understanding shown to patients who were waiting for long periods in the waiting room and in the department.

We observed kindness and staff treating people well. They gave as much time to the patient and any family as possible and were respectful and considerate of their privacy and dignity. They were non-judgemental and respected people's rights to make their own choices, even when they were not in their perceived best interests.

We were concerned about the patient experience when having to speak to both the streaming nurse and then receptionist when booking in to the department. We observed this was both frustrating and confusing for a number of patients, and not ideal for those who were unwell.

We recognised and were told how staff found it hard to have to explain and apologise, and too often, to patients who were being held in the department due to issues with capacity elsewhere in the hospital. We observed how staff were understanding and apologetic to patients in the waiting room and explained how some patients needed more urgent care.

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 Poole 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. For example, of the 10 patients in majors, 1 of them had been there for 11 hours and 4 were ready to be transferred to a ward. However, these patients had to remain in the department because there were no porters available to transfer them. When patients remained in the department and continued to require nursing care, this sometimes created a blockage that meant new patients waiting to come into the department were delayed. There had been lengthy delays for ambulance crews waiting to handover patients and consequently patients were 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.

Urgent and emergency services

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.

At times when the department was full, they used an escalation corridor to treat up to 4 additional patients. During periods of significant pressure, the hospital had an arrangement with the ambulance service to cohort patients in a hospital corridor. This improved the ability of ambulance crews to respond to emergencies within the community. The cohorting corridor contained 10 beds and was staffed by the ambulance service. Staff told us they understood the benefits of offloading ambulances but sometimes worried about the high risk patients who were being looked after there. Patient observations, blood tests, ECGs still needed to be carried out by the hospital staff so performing these tasks in addition to the doing this for the maximum number of patients that the department expects to deal with, meant nurses could be looking after more patients that the hospital had planned staff numbers for. However, when the department was at this level of escalation hospital leaders would move staff from other departments to provide support to the nursing team.

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.

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.

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. Overall trust activity rates increased by 31% between March 2021-February 2022.

Urgent and emergency services

The trust was part of a multidisciplinary team discussing frequent attenders, and what could be considered to support these patients with other services which were designed more for their needs. This included representation from the emergency departments, ambulance service, and social services. Regular attenders at A&E had care plans devised and these were evaluated at these meetings to determine if they were working or what else might be considered.

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 Poole and another located at The Royal Bournemouth 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.

Most staff said they regularly saw the trust leadership in the department and felt supported by members of the executive particularly by the chief operating officer when the department was in extreme escalation.

Culture

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

Staff 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. We noted how staff were regularly checking on each other to see if they were due a break and if it had been taken. 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.

A number of staff said how the introduction of international nurses and doctors and staff from different ethnic backgrounds had done much to improve the culture and positive diversity of skills and life-experience. 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 an 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 were concerned about the number of staff who told us they no longer reported some incidents. For example, some staff said they no longer reported incidents of violence or aggression unless it was "severe". Other staff told us they had stopped reporting long waits for mental health support for patients. However, staff who told us they reported incidents of violence, aggression, and verbal abuse from patients said they received a good level of support from managers as aftercare.

The trust had a policy to support staff experiencing bullying or harassment from colleagues. We spoke to a member of staff who had used this policy. They told us they felt fully supported by the trust and their incident had been fully resolved.

The annual NHS staff survey for the trust 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 trust 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 provides equal opportunities for career progression, indicating poorer experiences for them.

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.

Urgent and emergency services

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 they felt the department to always 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.

One of the recognised risks for the emergency department was with the provision of clinical support for patients experiencing a mental health crisis. There was little provision out of hours and at night when the department felt this was the most demanding time for patient's needs. 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.

Outstanding practice

We found the following outstanding practice:

- Urgent and emergency care had developed a system that used QR codes for reordering stock, this automated process included emails being sent to individuals with a role in stock monitoring and procurement. The system had resolved inconsistencies in stock levels.

Areas for improvement

MUSTS

Poole Hospital Emergency Department

- 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).

SHOULDS

Poole 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.

Urgent and emergency services

- 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 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.
- Hospital leaders should encourage staff to report all incidents of violence and aggression, and long waits for mental health support for patients.

Outpatients

Inspected but not rated

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Key services were available 5 days a week.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.

However:

- People could not always access the service when they needed it and had long waits for treatment.
- The service used multiple information systems as well as paper records for triage and booking of appointments. This meant there was a reliance on staff to ensure tracking of appointments.
- Surgical safety checklists were not completed which could lead to patients having the wrong surgery.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. Records showed 92.9% of staff had completed their training against a target of 90%. It was comprehensive and met the needs of the patients and staff. Managers monitored compliance and alerted staff when they needed to update their training. Staff told us they received reminders when their training was due, and their managers discussed this with them.

In July 2022, The Health and Social Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. This training was not in the current list of mandatory training for staff at the Trust, this will commence once the government has published the Code of Practice for the training as agreed by the Dorset Integrated Care Board (ICB).

Outpatients

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. Records sent to us by the Trust show that 100% of nursing staff had completed level 2 adult safeguarding training and 97.3% had completed level 2 child safeguarding training. The department had a paediatric safeguarding lead trained to level 3.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Staff followed safe procedures for children visiting the department. The Trust had a standard operating procedure (SOP) for children who were not brought for their appointments, this included how to respond when a child did not attend a scheduled appointment.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. It was difficult for staff to keep some of the equipment and the premises visibly clean.

Most of the clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, some of the seats in the waiting areas were fabric covered and stained, staff told us that it was difficult to clean these seats. They were wiped at the end of each outpatient session. Documents sent by the Trust showed there was a long-term plan to refurbish the waiting area and to replace the chairs.

The service did not always perform well for cleanliness. The environmental audit for infection control was not completed for 5 months from July 2022 until June 2023. Environmental audits for phlebotomy and the plaster room were undertaken as part of the main outpatient audit. However, results for each area were not separately reported. The Trust sent us documents to show that action plans were in place to improve this.

The infection control environmental audit for the main outpatient department was completed for 7 months between July 2022 and June 2023 and only achieved the compliance target for 1 month during that time. Evidence sent by the Trust showed that there had been issues completing the audits due to increased pressure on workload and staff sickness, audits submitted after the deadline were noted as non-submission. Work has been ongoing to improve the compliance through staff training and support from the infection control team.

We observed 1 procedure in a treatment room where staff followed infection control principles including the use of personal protective equipment (PPE). However, the hand hygiene audit data showed that compliance in the main outpatient area had only been met for 2 months between July 2022 and June 2023. This had been recognised by the Trust, senior staff told us they were supporting junior staff members to challenge poor practice in the department. The low rates of hand hygiene compliance were attributed to clinical staff visiting the department and not the staff who worked in the department permanently.

Outpatients

Environment and equipment

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

The main outpatient department was located on the ground floor of the hospital. This required patients coming from the main entrance or car park to use the stairs or a lift to go up from the lower ground level. There was a covered walkway from the car park to the hospital building. We saw wheelchairs available for patients in the covered walkway. Wheelchair patients could also access OPD from the emergency entrance without using a lift via the Urgent Treatment Centre (UTC) corridor.

National guidance for the design and layout of OPD takes into consideration that many patients who attend may have mobility problems and recommend the OPD should be located on the ground floor and that parking areas for disabled people and wheelchairs should be provided close to the main entrance. When parts of the OPD are not located on the ground floor the guidance recommends easy access by lift and stairs must be provided and access and circulation routes to and within the OPD should be sufficiently direct and clearly signposted to prevent patients losing their way (NHS Health Building Note Guidance 12).

Patients told us that it was very difficult for them and their carers to find car parking spaces, especially disabled spaces and that there was not enough space at the drop off point outside the hospital. Patients said they had to leave home early to get a parking space and be on time for their appointment. However, the trust had plans to move staff parking to another site to make more spaces for patients to park on site.

Records sent to us by the Trust showed a draft SOP for Children and Young people in Outpatients Department, this SOP had not yet been approved for use. The SOP stated that waiting rooms will provide separate areas for children and young people. During the inspection, we saw there was a ‘beach hut’ play area for children but this would not provide enough space for all children waiting for appointments. Parents were offered to use the 'beach hut' but often chose not to do so. The OPD aimed to manage the flow of children through the department to reduce the numbers of children in the area at one time. We saw children waiting in areas with adults and did not see a separate waiting area, this was not in line with national guidelines from the Nursing and Midwifery Council (NMC) 2016.

Hospital leaders understood the problems with the design and maintenance of the facilities. There was a long-term plan in place to refurbish the waiting area including walls and floors, and to replace the chairs to include extra seating in the clinical area.

Staff carried out safety checks of specialist equipment. We saw records that showed weekly checking of the resuscitation trolleys.

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

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. Sharps and hazardous waste bins were stored safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Risk to patients on the waiting list was not always identified.

Outpatients

New and existing patients sometimes had to wait for a long time to be seen by a doctor. In June 2023 the total waiting list size was 74,483 patients with 30,719 patients overdue a follow up appointment. The trust identified patients whose condition had deteriorated while they were waiting through the validation process or at their follow up appointments, so they could understand what had happened and learn from it. Waiting lists were amanged at speciality level with clinical oversight reviews and administrative validation. This meant that patients were being contacted to see whether they still needed to be seen or if they could be removed from a waiting list.

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us about a recent incident where a patient became unwell in the department and how they managed this, they knew who to call and what to do if there was a medical emergency. There were guidelines for staff to follow if a patient or visitor became unwell. The OPD had processes to admit patients who were too unwell to continue to be seen as an outpatient.

Staff met at the beginning of each day to share information to keep patients safe.

We observed one minor surgical procedure in the treatment centre. Staff checked the patient details and consent form prior to the procedure. However, staff did not complete the World Health Organisation (WHO) Surgical Safety Checklist. This is a national checklist designed to reduce surgical errors and enhance patient safety. The Trust had a policy regarding use of the World Health Organisation (WHO) Surgical Safety Checklist. The policy states it should be used for all patients including those having procedures under local anaesthetic. We looked at 3 patient notes following minor procedures and saw the checklist was not completed. We informed senior staff who immediately took action to address this. Following the inspection we were told that these records were being audited.

Staffing

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

The service had enough nursing and support staff to keep patients safe. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The manager could adjust staffing levels daily according to the needs of patients. Staff could rotate to work across various sites if needed. The number of nurses and healthcare assistants matched the planned numbers. The service had low vacancy rates for nursing staff. However, they had high vacancy rates for administration staff. The vacancy rate for administration staff was 14.94% in June 2023 this equated to 15.84 whole time vacancies for band 3 patient administrators. Managers told us that they were looking at ways to make the role more attractive such as offering flexible working, developing the role and having a clearer structure and career progression pathway. The trust informed us they had recently held a successful administration open day event where 12.86 posts had been offered.

The service had high sickness rates. The sickness rate for nursing staff was 10.3% over the last 12 months against the trust target of 3%. The service employed bank nurses to help cover staff absence. Managers requested bank staff who were familiar with the service. They made sure all bank staff had a full induction.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Outpatients

Patient notes in the treatment centre were not always completed fully, we reviewed 3 sets of paper notes in the treatment centre and found that the surgical checklist was not being completed consistently.

Most records were stored electronically with some paper records used in the treatment centre.

All staff could access records easily. They were stored securely. When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. All medicines and prescribing documents were managed and stored safely. Prescription forms were securely stored and records of their use completed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff told us they reported incidents electronically and received feedback on the incident once a manager had reviewed it. They raised concerns and reported incidents and near misses in line with the organisation's policy. Reports from investigations showed managers investigated incidents thoroughly. There was evidence that changes had been made as a result of identified learning from incidents. Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff told us about a safeguarding incident, how this was managed and that they received feedback following the incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers shared learning about never events and serious incidents with their staff and across the organisation. Never events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Managers debriefed and supported staff after any serious incident.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. For example, they offered virtual appointments for some specialities.

Outpatients

Facilities and premises were appropriate for the services being delivered. The service had systems to help care for patients in need of additional support.

Managers monitored and took action to minimise missed appointments. Patients were sent text message reminders prior to their appointments. Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. For example, they provided day case surgery in the treatment centre for some dental patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff mostly made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Reasonable adjustments were made to help patients access services. We observed staff booking transport to and from the hospital for patients who required it. Patients with mobility difficulties were supported by porters when they were moved to the discharge lounge.

Patients were encouraged to use the self check-in stations at the entrance of the OPD, these were touch screen monitors. The monitors offered check-in in different languages and told the patient which waiting area to use for their appointment. We saw some patients struggling to use these and were concerned that the main reception was not obvious to the patients as the screen was frosted which obscured the signage behind the desk. We saw patients going to another reception area desk to check in. Reception staff said that the screens could also cause problems for patients with hearing loss as they could not hear what the staff were saying.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment were not always in line with national standards.

Managers monitored waiting times and tried to make sure patients could access services when needed to receive treatment within agreed timeframes and national targets. In March 2022 there were 16,503 patients overdue follow up appointments, this figure went up to 46,556 in April 2022. We were told that this was due to two computer systems being merged and there were duplications, these were being checked during the validation process. However, the trust still had a significant backlog of patients waiting to be seen by some of the different OPD services. In June 2023 there were 30,594 patients overdue OPD follow up appointments. The backlog of patients waiting to be seen was partly due to the COVID-19 pandemic and associated social distancing requirements when patients could either not be seen at all or could only be invited to attend in small numbers. Recent staff industrial action had also affected the department as some clinics had been cancelled.

From March 2021 to February 2022 there were 694,982 OPD appointments at the trust, this was an increase of 23% from the previous 12 months. Initiatives to reduce backlogs had been introduced, for example insourcing clinics and patient waiting list initiatives running at the weekends.

Outpatients

The maximum number of weeks patients should wait to be seen by a doctor is set by the NHS Constitution to try and ensure people are seen in a specific timeframe. The longest time the Constitution says people should wait is 18 weeks for most non urgent referrals, and 2 weeks for a suspected cancer. Trusts are required to put in place systems and dedicated teams to ensure patients are tracked and monitored along their 2-week or 18-week pathway, with audit processes in place to ensure appointments have been made.

The total number of patients on the waiting list was 74,483 in June 2023 with 55.1% of patients being seen within the 18-week performance standard against a national target of 92%. There were 32 patients who had waited over 78 weeks for treatment. However, the Trust had no patients waiting for over 104 weeks and were planning to eliminate waits of over 65 weeks for elective care by March 2024.

From January to March 2023 only 76.9% of patients were seen by a specialist within 14 days of an urgent referral for suspected cancer. The faster diagnosis standard sets out that patients will be diagnosed or have cancer ruled out within 28 days of being referred for suspected cancer, 71.9% of patients met this standard in June 2023 against a target of 75%. The trust had not met this standard in the 12 months before our inspection.

Staff told us that most clinics ran on time. On the rare occasion they ran late it was because the doctor arrived late because they had been caught up in surgery or on a ward, because patients who needed to be seen urgently had been added to the list, or because an appointment had run over due to the complexity of a case or a distressed patient.

Managers worked to keep the number of cancelled appointments to a minimum. Staff told us it was rare for clinics to be cancelled and when this did happen it was usually due to staff sickness and an inability for staff to be sourced to cover the clinic. When patients had their appointments cancelled, managers made sure they were rearranged for as soon as possible.

Within OPD there were different IT systems for patient referrals and patient records. There was a lack of integration between these systems which meant the different systems were not able to communicate and share data with one another. This required administrative staff to print the referrals and send them to the individual specialities for triage and then upload them on to another system once they were returned. Managers told us that there was work under way to move this to an electronic format with a pilot starting in August 2023 so that the triage could be done electronically to reduce the risk of errors in the booking process.

Following a clinic appointment, patients were given a paper outcome form to give to the receptionist, this showed the outcome of the appointment and whether they required another appointment. The receptionists had to input this information on to the computer system. Managers told us they were working with the IT department to change this system to an electronic outcome form that would be completed by the clinician following the appointment which was being trialled.

Managers told us that the trust had plans to upgrade their digital systems and were planning to introduce a new Electronic Patient Record (EPR) system in 2025.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Outpatients

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. For example, staff told us they had provided water fountains for patients following feedback.

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.

The OPD had a clear senior management leadership structure. Matrons from other departments were supporting OPD staff because the OPD matron had retired. A new matron had been recruited to start in September 2023. There was a team of band 7 nurses who managed the department daily alongside the matrons. Senior staff told us that they were well supported by matrons from other departments and had been buddied with other matrons for support.

The trust ran 4 outpatient departments in Dorset. Since the merger in 2020, the outpatient departments had been working together to share leadership and resources and develop mutual systems and processes.

Leaders had the skills and abilities to run the service, they were committed to providing safe patient care and supporting their staff. Staff told us leaders were visible and approachable. Staff told us they were well supported by their line managers.

During our inspection we met with the senior leadership team and local leaders. Senior leaders told us about the issues the service faced and plans they had to overcome these. The main risks were the administrative staffing levels, the risk of using partly paper-based referral management and the lack of capacity to book follow up appointments within their given timeframes.

Vision and Strategy

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

There was a clear vision and set of values including quality and sustainability. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. Staff knew and understood what the vision, values and strategy were, and their role in achieving them. The service had priorities such as eliminating all patients waiting over 65 weeks for treatment by March 2024 and were on target to achieve this, this was included in the trust Operational Plan for 2023/24.

Outpatients

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. For example, the OAC had been set up to deliver care closer to the community and had included various stakeholders in the planning process including patient governors and the public at engagement events.

Progress against delivery of the strategy and local plans was monitored and reviewed. The trust had implemented an outpatient transformation programme with clear objectives and timelines, this was part of a Dorset-wide outpatient transformation programme. Following the inspection the trust informed us that the previous OPD matron is returning part time in September 2023 for a year to support with the transformation work with the outpatient's service.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke to felt supported, respected, valued and were positive and proud to work in the organisation, they told us that the culture and morale in the OPD had improved. The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

The senior nurses had introduced 'thank you Thursday' as a way of thanking colleagues, they had also arranged social events for all staff such as crazy golf and a staff barbeque. The department recently created a staff room with all staff involved in its development. Staff told us this had made a big difference for them as they did not have to leave the department for breaks.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, there were daily huddles where staff could raise issues. Some staff told us they felt that 'everyone is listened to equally'. Managers told us they worked together across all 4 outpatient sites, they met regularly to discuss issues and support each other, they were working together to standardise policies across the 4 OPD sites.

The annual NHS staff survey for the trust took place between October and November 2022. OPD Poole nursing staff results showed that 60.9% looked forward to going to work and 79% felt the organisation treats staff who are involved in an incident fairly. However, nearly three quarters of nursing staff (73.9%) in Poole OPD said they would feel secure raising concerns about unsafe clinical practice which is better than the national average of 70.7%. There was an action plan developed from the results of the staff survey, this included areas for the senior nursing team to focus on. For example, giving staff the opportunity to attend courses to gain new skills and looking at progression posts within the department.,

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Outpatients

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Leaders monitored key safety and performance metrics such as the 18 week wait times.

Most levels of governance and management functioned effectively and interacted with each other. Some leaders told us there could be improvements in communication between the OPD and the medical and surgical care groups. The trust had 3 care groups; these oversaw the governance for medical, surgical and other specialities.

The OPD governance of waiting lists was managed by the individual specialisms that saw outpatients, for example, ophthalmology or urology and their wider core service. Governance arrangements were not coordinated as a single OPD. There were different committees that met to discuss performance and risk, their concerns were escalated to the Board of Directors.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

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.

The trust had systems for recording, reviewing and managing risks. There was a risk register for OPD, each risk had been given a score depending on the level of risk and these were reviewed regularly. For example, we saw minutes of meetings showing the risk score of for staffing levels had reduced as the service recruited more staff.

The OPD quality and risk group met monthly, we reviewed minutes of the meetings and saw that risks and issues were discussed and actions identified to reduce their impact. Leaders were clear on the links to trust wide groups and committees to escalate risks and issues.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. The main risks were insufficient capacity to book follow-up appointments within due dates, outpatient staffing and the risk of using partly paper-based systems for referral triage. Board members were aware of the extreme risks, and these were reviewed by them monthly.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required, however, not all information systems were integrated.

Information was used to measure improvement. For example, the trust had recently achieved no patients waiting over 104 weeks for elective treatment. They analysed key performance data monthly and reported on this.

Staff had sufficient access to information. Senior leaders showed us the 'outpatient dashboard' an IT function which supported specialities to understand where they were against the outpatient performance targets. There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. Reports of patient backlogs were regularly sent to individual specialities to manage their waiting lists.

There were arrangements to ensure data or notifications were submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. Lessons were learned when there were data security breaches. For example, during the test phase of a new system, 20,000 text messages were sent in error by an external provider. We saw meeting minutes of the incident and lessons learnt.

Not all information systems were integrated, this was a known risk on the trust risk register. There were plans in place to implement some changes in the short term to help mitigate these risks. Senior leaders told us there were plans to upgrade digital systems by 2025.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve services. The service used the family and friends test to capture patient feedback. In April 2023, the Poole OPD had 16235 responses and 94% of responses said their experience was good. We saw friends and family information posters displayed with 'you said' and 'we did' showing what the service had done to improve following feedback. However, the staff survey results showed that only 56.5% of staff felt able to make suggestions to improve the work of the team, and only 34.8% felt able to make improvements happen in their area of work.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and understanding of the needs of the relevant population, and to deliver services to meet those needs. The Dorset Elective Health Inequalities Group was established in 2022. They aimed to ensure that patients with a learning disability had their first outpatient appointment within 18 weeks, and they monitored population health data to assess the impact of the elective recovery programmes on patients' access, experience and outcomes.

The trust were part of the Outpatient Transformation Programme Steering Group, this was a collaboration between the trust and partners/stakeholders.

The OAC collaborated with partner organisations and included free services which supported individuals to move more, drink less, stop smoking and maintain a healthy weight.

Learning, continuous improvement and innovation

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

Leaders and staff aspired to continuous learning, improvement and innovation. The Trust had seen a progression of digital outpatient transformation in 2022/23 they had launched a patient portal (DrDoctor), installation of virtual consulting pods, extension of Bookwise (a scheduling system for the booking of clinics and rooms) room booking capability for Christchurch and Poole, and introduction of InTouch digital check in at Bournemouth and Christchurch hospitals.

Outpatients

The trust had started to implement patient initiated follow up (PIFU). This is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances. This ensures patients can see a specialist sooner than planned if they need to, as well as avoid an unnecessary trip to hospital if they have no need to be seen. It also helps clinicians manage their waiting lists in a safe and effective way. For patients, this means more choice and flexibility around when they access care.

There were standardised improvement tools and methods, and staff had the skills to use them. Learning from internal and external reviews was effective and included those related to mortality or death of a person using the service.

There were systems to support improvement and innovation work, data systems, and processes for evaluating and sharing the results of improvement work. For example, there was a health inequalities programme using data systems and processes to evaluate and improve the equity of access, experience and outcomes to reduce health inequalities.

Areas for improvement

Action the trust MUST take to improve:

Poole Outpatients

- The trust must continue to do all that is reasonably practicable to reduce waiting times to treatment. Regulation 12(2)(a)(b).

- The trust must ensure that surgical safety checklists are completed in line with national guidance, so surgical safety is improved. Regulation 12(2)(a)(b).

Action the trust SHOULD take to improve:

Poole Outpatients

- The trust should ensure staff receive training in how to interact appropriately with autistic people and people who have a learning disability. This should be at a level appropriate to their role. Regulation 18(2)(a).

- The trust should ensure that chairs in the waiting room are covered in a wipeable material for infection control purposes. Regulation 12(2)(h).

- The trust should ensure that environmental audits are completed regularly and that they continue to challenge poor hand hygiene practice. Regulation 12(2)(h).

- The trust should have a separate waiting area for children in line with NMC guidance.

- The trust should ensure it meets accessibility standards so people with protected characteristics are not unfairly disadvantaged and have equal access to services. Regulation 9(1)(a)(b).

Our inspection team

For the urgent and emergency care service 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 32 members of staff (including managers, doctors, nurses, healthcare assistants, healthcare professionals, receptionists and administrative staff). We reviewed 24 sets of patient notes, we attended 1 meeting.

For the outpatient department a team of 1 inspector and 1 specialist advisor visited Poole Outpatients. We spoke with 10 members of staff (including managers, nurses, healthcare assistants, dental nurses and receptionists). We spoke with 6 patients, reviewed 3 sets of notes and observed 1 patient undergoing a minor surgical procedure.

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 17 HSCA (RA) Regulations 2014 Good governance

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