Dorset County Hospital NHS Foundation Trust

Quality Report

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Date of inspection visit: 8 - 10 March 2016
Date of publication: 16/08/2016

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Dorset County Hospital NHS Trust has a single site acute hospital, Dorset County Hospital, and has been a foundation trust since 2007. The trust provides acute and some community services to a population of around 250,000, living within Weymouth and Portland, West Dorset, North Dorset and Purbeck. It also provides renal services for patients throughout Dorset and South Somerset to a total population of 850,000. The geographical spread of the community means the trust also delivers satellite services in other NHS locations including local community hospitals.

Dorset County Hospital has approximately 400 inpatient beds. We inspected the following core services at Dorset County Hospital : Urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, children and young people, end of life care, outpatient and diagnostic services. We inspected satellite outpatients, day surgery and renal dialysis at two other NHS locations.

We inspected this trust as part of our planned, comprehensive inspection programme. We carried out an announced inspection visit to the hospital from 8 to 10 March 2016, and additional unannounced inspection visits between 16 and 21 March 2016. During this time we also visited outpatients, day case surgical services and dialysis services provided at two other trust sites.

Overall, we rated this trust as 'requires improvement'. We rated it 'good' for providing a caring and 'requires improvement' for safe, effective, responsive and well led services. At provider level, we rated 'well led' as requires improvement.

We rated, medical care, surgical services, critical care and services for children and young people as good. Urgent and emergency care, maternity and gynaecology, end of life care and outpatient services were rated as requires improvement.

Our key findings were as follows:

Is the trust well-led?

- The trust was in the process of reviewing its strategy, focusing on strengthening collaboration and partnership working with other organisations to deliver integrated and more sustainable services, with better outcomes and experiences for patients. The strategic goal was that Dorset County Hospital would become a leading integrated healthcare hub with a range of secondary and primary care services located on the site. The strategy and services of the trust would in part be determined by the outcome of the Dorset Clinical Services Review and the work of the Developing One NHS in Dorset Vanguard.
- There was a commitment to safe care and improving performance across the trust. The executive team recognised the need for a shift of focus to develop a culture of continuous quality improvement supported by a consistent governance framework. This had not yet been achieved and the board was not sufficiently informed about the improvements needed in some services such as end of life care.
- Improvements were needed in the governance arrangements at the Trust. Recent external reviews confirmed that ward to board governance and reporting for trust wide assurance on quality needed improvement. The senior management were using the findings and recommendations to develop, for example, a quality strategy, a governance framework, and an improved mortality review process.
- Progress and improvement against quality improvement projects was inconsistent across the trust. The trust identified that quality improvement training was needed within the leadership training programme, a key strand of the recently developed People Strategy.
- Trust wide staff had contributed to the recently developed set of values and behaviours to support the delivery of compassionate and safe care. Staff were positive about working for the trust and the quality of care they provided, many described the hospital as more than a place of work. They described a trust culture that was open and patient focused.
- The NHS staff survey demonstrated staff engagement was similar to trusts nationally. The

Summary of findings

trust had taken some actions to ensure Black, Asian and minority ethnic groups had similar equal opportunities and career progression. Action was ongoing to improve this.

- There was a wide range of public engagement and involvement. The trust had developed innovative ways of engaging patients and obtaining feedback to improve services, including 'patient based experience' methodology.
- Cost improvement programmes were identified with clinical staff, and these were assessed and monitored to reduce the impact on quality and risk. However, expected savings had not been achieved in all areas and increased activity was contributing to costs and ability to make savings in the future. The trust was continuing with its financial recovery plan to reduce its financial deficit and would need to negotiate its current position under the national sustainability transformation plans.

Are services safe?

- The majority of staff understood when to report an incident, these were investigated and lessons learnt shared. However, some staff in outpatients and diagnostic imaging felt discouraged from using the system as they did not always receive feedback and lessons learnt were not always shared. Some staff in surgical services were using a supplementary paper-based system which was outside of the trust policy. There was a high level of harm-free care. Staff were aware of the Duty of Candour legislation and the service had a system for tracking incidents that triggered a Duty of Candour response.
- Systems were in place to enable staff to assess and respond safely to deterioration in patients' health.
- Medicines were generally stored and managed appropriately other than the small amount of emergency medicines stored insecurely in the emergency trolleys. Some Patient Group Directions (PGDs) held in departments were not the most current versions, as not up to date and authorised. PGDs are instructions that permit authorised to staff to give medicines to patients without the patients having an individual prescription. PGDs need to be accurate and authorised to protect staff and patients. Staff had not followed trust policy for updating PGDs in some departments.
- The mandatory training target set by the trust at 85% had not been met across all areas of the trust.
- Safeguarding training compliance had increased to meet the target. Staff were aware of the procedures for safeguarding of vulnerable adults and children. Children safeguarding checks were always undertaken, and processes were in place to escalate concerns to the local authority if needed.
- Regularly serviced and maintained equipment was available for patients' use in most areas, with a prompt response from the maintenance team when equipment required repair. Some equipment in the emergency department was not clean or fit for use.
- Patient records were not always secured safely, in lockable storage equipment to ensure confidentiality.
- There were not always enough nursing, midwifery, therapy and medical staff with the right skill mix to provide safe care. Staffing levels had been reviewed, but changes to staffing levels identified as necessary from the reviews had not been fully implemented at the time of the inspection. The trust had a lower proportion of middle grade doctors than the national average, which put pressure on the medical teams. The trust was working to improve this.
- Staff adhered to the bare below the elbow policy and maintained safe standards of infection prevention. The trust scored higher than the national average for cleanliness in the patient-led assessments of the care environment (PLACE), scoring 99%. The hospital's infection control team carried out audits which led to improvements in standards of hygiene. However, the procedure for using the mortuary trolley did not adhere to infection control policies or procedures.
- Some parts of the environment in the emergency department were in need of repair and made cleaning difficult.

Summary of findings

- In the operating departments, staff did not consistently complete the 'Five Steps to Safer Surgery' checklist to minimise the risk of patient harm.

Are services effective?

- Most services followed pathways and protocols based on national guidance, such as the National Institute for Clinical Excellence (NICE) guidelines. Generally, patients' care was planned and delivered in line with current evidence-based standards. There was monitoring of performance against national targets and the results of audits were used to improve treatment.
- However on the maternity unit care and treatment did not consistently take account of current guidelines and legislation. For example we found some women did not have ongoing mental health checks throughout pregnancy, the maternal pulse was not consistently recorded on commencing a CTG trace for foetal wellbeing, and CTG traces were not reviewed in line with best practice guidelines.
- The trust was recently more focused on improving end of life care for patients. But there had been a slow response to best practice guidance and the results of successive national care of the dying audits. The Achieving the Five Priorities for Care of the Dying Person care plan was in the process of being introduced, and its use was yet to be audited.
- The majority of staff were trained and had the skills and knowledge required to undertake their role. There were educational opportunities available for all grades of medical and nursing staff. There were arrangements in place for the supervision and appraisal of staff. Although not all staff on the CRCU and in diagnostic and imaging had received an annual appraisal.
- On the maternity unit, most of the consultants performed a limited number of caesarean sections, which had the potential to impact on their competence. Also in maternity, consultants did not always give adequate supervision to junior registrars. There was little communication from the consultants to the nurses looking after the gynaecology patients and their attendance was described as "variable".
- Patients' consent for treatment, observation or examination was sought by staff. When people lacked mental capacity to make decisions, staff understood their responsibilities around making best interest decisions. Staff were aware of the impact of the Mental Health Act (2005) and the Deprivation of Liberty Safeguards. However, not all 'Do not attempt cardiopulmonary resuscitation' forms were supported by mental capacity assessments when it was stated patients lacked capacity.
- The trust was still working towards a full 7-day service. There was access to physiotherapy, pharmacy and microbiology seven days a week. The critical care outreach team was only available Monday to Friday 8am -8pm and there was no formal 'hospital at night' service. While staff said there was good access to the palliative care team and said they were helpful and supportive, there was not a face-to-face specialist palliative care service, seven days per week. Women who were at risk of miscarriage were only offered scans between Mondays and Fridays. Women were required to attend the emergency department or were referred to a neighbouring trust out of hours.
- Pain management was variable across the hospital. Patients who had undergone surgery told us their pain levels were regularly assessed and they received adequate pain relief. Pain assessment tools were not used for patients who had difficulty communicating verbally and patients' pain was not being routinely monitored or managed effectively in the critical care unit.
- Information was not always provided to the patient's GP in a timely manner. There had been a delay in providing discharge letters and clinic letters for cardiology patients, and clinic letters for dermatology and haematology patients.
- There was effective multidisciplinary working with staff working together to provide patient care in a coordinated way.

Are services caring?

- Patients and their relatives were positive about the caring attitude of staff and said staff treated them with dignity and respect.

Summary of findings

- Patient surveys showed that staff were caring and protected people's privacy and dignity. The hospital's 'patient-led assessment of the care environment' (PLACE) audit score for privacy and dignity was 92%, above the national average of 86%. Friends and family test results were generally positive with the majority of people happy to recommend the hospital.
- Patients said they felt involved in their treatment and had been able to make their own decisions.
- The multi-faith chaplaincy service was available to provide emotional and spiritual support if requested. Patients also said staff helped them emotionally with their care. However, there was no psychology service at this trust so critical care patients with complex emotional needs could not be referred for formal psychological support.

Are services responsive?

- The hospital often faced challenges with patients' flow through the hospital and the number of available beds. The bed occupancy was consistency above the England average. The staff took a flexible approach to managing this situation including opening additional beds when able to do so. Other initiatives to improve the access and flow of patients through the hospital and, to promote shorter lengths of stay included the hospital@home service. Discharge planning was instigated at the time of admission. Ward staff and the discharge team worked with partners to improve the coordination of patient discharges and transfers, but not all wards made effective use of the discharge lounge.
- Improvements were needed in the responsiveness of critical care, and maternity and gynaecology services. There were delayed transfers from the critical care unit, which was not a suitable environment for patients ready for care on a ward.Mixed sex breaches were not identified and reported in line with national guidance.
- Services were planned to meet the needs of the local population and in coordination with other health and social care services.These included the services provided in the hospital site and those provided at other locations such as dialysis services in satellite units. Patients with respiratory problems had access to the Dorset adult integrated respiratory service (DAIRS) a small outreach service that coordinated care between the hospital and patients' own homes.There was a day surgery unit in Weymouth, and a one stop breast clinic for timely and accurate diagnosis for patients awaiting breast cancer diagnosis. Outpatient clinics and diagnostic imaging were available at community clinics.
- There were translation services available for patients whose first language was not English. Sign language interpreters were also made available. Patient information was available and could be provided in other languages on request.
- Staff understood how to provide support to vulnerable people, including those living with dementia or a learning disability or difficulty. There was no specialist liaison nurse for learning disabilities.
- Staff tried to resolve patients' concerns before they became complaints. Complaints were taken seriously, and changes made in response to patient feedback. There were improvement plans for improving timeliness of responses, in line with response times agreed with individual complainants.

Are services well led?

- Service leads had identified priorities for improvement, although the strategic vision was in part dependent on the Dorset Clinical Services Review. Strategies were also driven by the recent Vanguard project for more coordinated acute services across Dorset.
- Service leads had articulated a vision and the priorities for end of life care services, but these had not been implemented. The leadership and governance of end of life care services had not been sufficient to ensure that necessary action plans were implemented in a timely way, and that quality, performance and risks were effectively monitored and managed.
- Staff were aware of the trust's vision. All staff were passionate about improving services and providing a high quality service. Most staff felt both the trust and local leadership teams were visible and supportive. The exception was the maternity and gynaecology

Summary of findings

service where consultants did not all work well as a team and working relationships were strained. In some areas, managers were put under pressure to work clinically and were then not able to complete all aspects of their role.

- There was strong patient and staff engagement including 'experience based design' surveys to find out how people felt about their care and treatment. Many of the wards displayed recognition awards for teams and individual staff.
- There was a governance structure for the services and services participated in audit programmes. A recent trust wide review had demonstrated that the governance processes including the reporting and escalation process needed strengthening. At local level the clinical governance teams had variable oversight of audit, performance, risks, quality and finance. A newly formatted risk register had been introduced, the completion and use of these registers varied. Not all risk registers included all the risks and lacked evidence of mitigation and review.

We saw several areas of outstanding practice including:

- The hospital@home service provided a valuable service supporting medically fit patients to have earlier discharges to their homes. This service was provided 24/7 and helped improve access and flow in the hospital as well improving outcomes for patients.
- The support for renal dialysis patients was outstanding, with individualised care for patients to receive home dialysis and holiday dialysis when appropriate and safe.
- The genitourinary medicine service was a well-led, patient focused service that had identified the needs of the patient groups it served, many of whom were vulnerable. There was excellent multi-disciplinary working with external agencies and robust clinical standards in place, which the service, audited themselves against, always looking for how they could improve the service. Outpatient clinics and advice sessions were held, where possible, at venues that encouraged attendance from patients who had the greatest need for the service but could not attend or found it challenging to attend a hospital.
- The two bereavement midwives made home visits following a stillbirth or neonatal death. They made follow up visits to tell the parents post-mortem results in person and offered to provide antenatal care for women in any subsequent pregnancy. They also set up the monthly 'Forget Me Not' bereavement support group in a local children's centre. They set up and closely monitored a private social media page for women who had lost a baby during pregnancy or after birth.
- A gynaecology specialist nurse ran the 'Go Girls Support Group' along with a former patient, to provide support for women diagnosed with a gynaecological cancer.
- Midwives ran specially designed antenatal, breastfeeding and smoking cessation sessions for 'Young Mums'. They were also offered separate tours of the maternity unit.
- There were several examples of patient involvement in the co design and improvement of services and excellent use of experience based design (EBD) methodology.

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

Importantly, the trust **must** ensure:

- All equipment is clean and fit for purpose and ready for use in the emergency department. A clear process must be implemented to demonstrate the mortuary trolley has been cleaned, with appropriate dates and times recorded.
- The five steps to safer surgery checklist is appropriately completed.
- Patients in the minor operations room (used as a majors cubicle) in the emergency department have a reliable system in place to be able to call for help from staff.
- There are sufficient therapy staff available to provide effective treatment of patients.
- The numbers of nursing on duty are based on the numbers planned by the trust all times of the day and night to support safe care.

Summary of findings

- Sufficient palliative care consultant staffing provision in line with national guidance and to improve capacity for clinical leadership of the service
- The number of midwives is increased according to trust plans and in line with national guidance, to support safe care for women.
- Staff attend and or complete mandatory training updates.
- Turnaround times for typing of clinic letters are consistently met, monitored and action taken when targets are not met across all specialities within the trust.
- All patient records must be stored securely to maintain patient confidentiality.
- Risk registers at local, directorate and divisional level are kept up-to-date, include all factors that may adversely affect patient safety, and progress with actions is monitored.
- There is implementation of clear and measurable action plans for improving end of life care for patients. There is monitoring and improvement in service targets and key performance indicators, as measured in the National Care of the Dying Audits.
- Care and treatment in all services consistently takes account of current guidelines and legislation and that adherence is audited.
- Consultants supervise junior registrars in line with RCOG guidance.
- Continue the development of governance processes across all specialties and divisions, with a standardised approach to recording and reporting. Ensure the information is used to develop and improve service quality.
- Regular monitoring of the environment and equipment within the emergency department, and action taken to reduce risks to patients.
- Mixed sex breaches in critical care must be reported within national guidance and immediately that the breach occurs.

The trust should ensure:

- There are quarterly reports to the Board on progress against implementation of standards for patients with a learning disability.
- There is formal, systematic review and benchmarking against the recommendations in the Francis review 'freedom to speak up' report.
- Recommendations from the external mortality review are implemented.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Dorset County Hospital NHS Foundation Trust

Dorset County Hospital NHS Trust has a single site acute hospital, Dorset County Hospital, and has been a foundation trust since 2007. The trust provides acute and some community services to a population of around 250,000, living within Weymouth and Portland, West Dorset, North Dorset and Purbeck. They also provide renal services for patients throughout Dorset and South Somerset to a total population of 850,000. The geographical spread of the community means the trust also deliver satellite services, outpatients, day surgery and renal dialysis, at five other NHS locations. It serves an area with a higher than average elderly population and lower than average proportion of school aged children. Dorset continues to experience an increasing total population.

Dorset County Hospital has approximately 400 beds including 32 maternity beds and eight critical care beds with seven main theatres and two day theatre and employs around 2401 whole time equivalent staff. The Trust provides full emergency department services including critical care (the hospital has trauma unit status); acute and elective (planned) surgery and medical treatments; outpatient services; services for older people; acute stroke care; cancer services; pharmacy services; comprehensive maternity services including a midwife-led birthing service, community midwifery support, antenatal care, postnatal care and home births. The trust also has a special care baby unit and a neonatal intensive care baby unit; children's services including emergency assessment, inpatient and outpatient services; diagnostic services such as fully accredited pathology, liquid based cytology, CT scanning, MRI scanning, ultrasound, cardiac angiography and interventional radiology; a wide range of therapy services and an integrated service with social services to provide a virtual ward enabling patients to be treated in their own homes.

We inspected this hospital as part of our planned, comprehensive inspection programme. We carried out an announced inspection visit to the hospital from 8 to 10 March 2016, and additional unannounced inspection visits between 16 and 21 March 2016.

We inspected the following core services at Dorset County Hospital : Urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, children and young people, end of life care, outpatient and diagnostic services.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop, (retired) Medical Director; National Professional Advisor at CQC

Inspection Manager: Anne Davis, Care Quality Commission

The team of 46 included CQC inspection managers, inspectors and assistant inspectors and a variety of specialists: including a consultant in intensive care medicine, consultant gynaecologist and obstetrician; consultant surgeon; consultant geriatrician, consultant radiologist; consultant paediatrician and neonatologist, emergency nurse, midwife, theatre nurse, paediatric nurse, palliative and end of life care nurse and consultant; critical care nurse; board-level clinicians and managers, a governance lead; safeguarding lead, a junior doctor and one expert by experience.

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out an announced inspection visit to Dorset county hospital 8 to 10 March 2016, and additional unannounced inspection visits between 16 and 21 March 2016. During this time we also visited Out patients, day case services and dialysis services provided at two other trust sites.

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

We held listening events at a local library and shopping centre. This enabled local people to tell us about their views and experiences of Dorset County Hospital NHS Trust.

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

During our inspection we spoke with approximately 100 patients and 390 staff from all areas of the hospital. We observed how people were being cared for and talked with around 33 carers and/or family members and reviewed 187 personal care or treatment records of patients.

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

What people who use the trust's services say

We held public listening events, on 24 February and 3 March 2016. We spoke to 50 people. We met them in Dorchester and Weymouth library and in Dorchester shopping area. We also received 36 enquires for people who 'shared their knowledge' with us via our website and phone enquiries.

Overall people gave us positive views about the trust:

The majority of comments were positive:

- Staff were described as conscientious, caring, reassuring, helpful and friendly
- Staff very good at dealing providing holistic care to meet people's needs
- Positive experiences of care and treatment in the emergency department
- Examples of good treatment and care in surgery and medicine services
- Paediatric services with 'fantastic staff' good facilities and toys for children
- Positive experiences of care in maternity services

The negative comments were on the following:

- Waiting times and staff attitude in urgent care
- Long waits for appointments in ophthalmology, musculo skeletal services and respiratory departments and some surgery
- Some examples of poor discharge arrangements from wards

Summary of findings

- The results of the NHS Friends and Family Test (FFT) were consistently positive. The trust scored above the England average for inpatient wards (December 2014-November2015).
- The CQC adult inpatient survey (2014):The trust had performed similar to other trusts across most questions with scores in the top 20% for one of the 12 questions; help from staff to eat meals.
- The CQC A&E survey (2014):The trust achieved the top overall score in the country, with score in the top 20% for the majority of questions.
- The Cancer Patient Experience Survey (CPES) by the Department of Health 2013/14 is designed to monitor national progress on cancer care. The trust performed well across the 34 questions, with scores in the top 20% of trusts for 11 questions and similar to other trusts in 22 questions. The trust was in the bottom 20% of trusts for one question, patients given the name of the clinical nurse specialist in charge of their care.
- CQC Children's survey (2014): The trust scored similar to other trusts overall and was better than other trusts for three questions related to staff providing information and advice about care and treatment.
- CQC's Survey of Women's Experiences of Maternity Services 2015: The trust scored in the top 20% for confidence in staff care and similar to other trusts for other questions.
- Patient-led assessment of the care environment (PLACE) were self-assessments undertaken by teams of NHS and independent healthcare staff, and also by the public and patients. They focused on the environment. In 2015, the trust scored higher than the national average for cleanliness (100%, compared to 98% nationally), food (93%, compared to 88%), facilities (94%, compared to 90%) and privacy, dignity and well-being (90%, compared to 86%).

Facts and data about this trust

Key facts and figures:

Context and activity

- This organisation has one acute hospital location: Dorset County Hospital, and satellite outpatient renal services across Dorset, including Weymouth community Hospital where there is a day surgery unit.
- It provides acute services to a local population of 250,000 in West Dorset and regional renal services to a population of 800,000 across Dorset and parts of Somerset.
- There are 400 inpatient beds. In 2014-2015 , there were 21,457 inpatient admissions, 289,014 outpatient attendances, and 42,367 attendances at the emergency department.
- The Clinical Commissioning Group (CCG) for this trust is Dorset CCG.
- In November 2015 the trust employed 2424 whole time equivalents (WTE) staff, of which 322 were medical, 704 nursing and 496 'other clinical' and 903 'other non clinical'.
- The trust has an annual turnover of £158,319,000, and in 2014/15 the deficit was (-) £710,000.
- Bed occupancy overall was higher than the England average.

Safety (trust wide)

- There were two never events reported in the trust and 46 serious incidents between October 2014 and September 2015.
- There were 4,130 incidents reported to the National Reporting and Learning System (NRLS) in December 2014 – November 2015. The rate of NRLS reported incidents per 100 admissions was 0.4% lower than the England average: 8.4 per 100 admissions, against an England average of 8.8 per 100 admissions.

Number of incidents -% against (England Average %)

Deaths 3 - 0.07%(0.12%)

Severe Harm 29 - 0.66%(0.34%)

Moderate Harm 60 -1.38% (2.93%)

Summary of findings

Low Harm 901 - 20.7% (21.92%)

No Harm3357 - 77.1% (74.67%)

- There were 19 cases of Clostridium Difficile (C-Diff) in this trust between August 2014 and July 2015, and one case of for methicillin-resistant staphylococcus aureus (MRSA).

Effective (trust wide)

- The hospital standardised mortality ratio (HSMR) for this trust for October 2014 and December 2015 was 118.02, this is higher than expected.
- The summary hospital-level mortality indicator (SHMI) for this trust for October 2014 and December 2015 was 1.13, again higher than expected.
- The trust performed similar to the England average for most indicators in the GMC National Training Scheme Survey, but significantly below average in four areas and significantly above in five areas, across a range of services. The aggregated feedback was negative.

Caring (trust wide)

- This trust performed similarly to other trusts in the CQC 2015 in-patient survey. It had consistently better scores than the England average for both the PLACE indicators and the Friends and Family test.
- The trust received 385 complaints between 2014 and 2015.

Responsive (trust wide)

- A&E four hour target was not always met, but overall it was above the England average. The 95% target was met for five out of the seven months from May to November 2015.
- The 92% referral to treatment standard for incomplete pathways was met for seven out of the 12 months from Dec 2014 to Nov '2015.
- 16.6% of delayed transfers of care in the trust were "waiting for further NHS non-acute care", which was lower than the England average.
- 1560 patients were awaiting "completion of assessment". At 19% this was relatively higher than England average 18.5%.
- 26.7% (2,184 patients) of delayed transfers of care in the trust were due to "awaiting nursing home placement or availability", this was higher than the England average of 12.6%.
- There were 823 patients with delayed care due to public funding; that equates to 10% which is higher than the England average of 4.5%
- The trust was meeting cancer waiting times for patients to see a specialist within two weeks of referral and from decision to treat to first definitive treatment within 31 days. The trust also met the waiting times target for two week wait referral to first definitive treatment within 62 days, this was just below 85% target at 84.5%.

Well led (trust wide)

As of November 2015 there were 2424.2 WTE staff working in this trust. The numbers of staff by staff type are given below:

Nurses 704

Doctors 322

Other 1399

Total 2424

(NB: 'Other' includes allied health professionals, other clinical staff including healthcare and maternity care assistants, and non-clinical staff.)

- Staff sickness in this trust was 4.8% in the last financial year and there was a turnover rate of 6.4% in April 2015 to March 2016.
- At November 2015, the contracted WTE medical headcount was approximately 322, and the skill mix percentage for each grade of doctor was: Consultants 39%, Middle Career 14%, Registrar group 28% and Juniors 20%.
- The trust performed similar to the England average for the majority of indicators in the NHS Staff Survey 2014, but also achieved 2 positive findings and 1 negative finding (out of 31 indicators). The response rate was 55%.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **By safe, we mean that people are protected from abuse and avoidable harm.**	Requires improvement 

Overall we rated the safety of the services at the trust as 'requires improvement'. For specific information, please refer to the report for Dorset County Hospital NHS FT.

In November 2014, the trust signed up to the national 'Sign up to Safety' initiative which aims to reduce harm in the NHS by 50% over three years (2015 – 2018). The trust had developed a work programme against the five selected priority areas: sepsis, acute kidney injury, pressure ulcers, falls reduction, documentation and transfers of care. There were identified leads and action plans aligned to each of the priority areas. There was evidence of some actions being taken but the speed of progress was variable and the use of tools for audit and improvement measures were not fully embedded.

We identified areas that required improvement across services. In many areas safety standards were being adhered to but not consistently across all areas and this put patients at risk. We identified particular areas that required improvement; staffing, security of records and in some areas, incident reporting. There were some specific issues related to medicines management and infection prevention and control, but otherwise they were managed well. The trust's infection rates for MRSA (none reported), and C-Diff was low when compared with trusts of similar size and complexity. The rate for MSSA was higher than the national average for 10 out of the 13 months from August 2014 to August 2015.

Assessing and responding to risk

- Patients arriving to the emergency department by ambulance were assessed and treated within national standard times and quicker than the England average .
- Staff carried out risk assessments and management plans for patients in a timely way although this was not entirely robust within the obstetrics and gynaecology services.
- The early warning score system was being used but this needed to be used more reliably for the escalation of patients whose condition might deteriorate.

- In some operating theatres, staff did not follow the five steps for surgical safety reliably or accurately in order to minimise the risks to patients.
- The trust's February 2016 board report showed the harm free care, safety thermometer measurement, was 97.9% on the day of capture, which was in line with the monthly trend for the year. The trust target was 100%. The shortfall was due to higher than expected pressure ulcers and falls with harm.

Duty of Candour

- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust's policy on 'being open and duty of candour' reflected the DoC legislation.
- Senior clinical staff were aware of the DoC regulation and the importance of being open and transparent with patients and families. Staff we spoke with were familiar with the concepts of openness and transparency and some could give examples of how they or their colleagues had applied the DoC.
- The risk management team identified incidents reported by staff that triggered the DoC and then coordinated the response and investigation. The complaints team submitted an incident for any instances requiring follow up under DOC. All significant incidents were subject to review by a scrutiny panel. There was a process for inviting patients / families to meetings and letters of apology were sent by the CEO,. In the quarter October 2015 – December 2015, 9 incidents triggered the DoC response.
- There was ongoing review of the DoC policy and responsibilities, including assurance processes on how this was being discharged.

Safeguarding

- The trust had separate adults and children safeguarding committees/boards. The interim director of nursing was safeguarding executive lead and chaired the safeguarding boards. There were separate safeguarding adults and safeguarding children policies. These were regularly updated in line with national and local best practice. A senior nurse was the safeguarding adults lead and there was a named doctor, nurse and midwife for children's safeguarding.

- The trust safeguarding adults annual report January 2016 report (2014/15) covered a range of issues including safeguarding adults at risk, responding to domestic abuse, the Mental Capacity Act, Deprivation of Liberty Safeguards, and compliance with Prevent Strategy.
- Child protection procedures were followed and there had been an increasing number of alerts demonstrating increasing recognition and action regarding vulnerable children and young people. The trust safeguarding children annual report January 2016 referenced key issues, external reports and new guidance in safeguarding children.
- The board received quarterly updates on actions to implement recommendations from the Saville investigation report.
- The trust was working with partners to ensure an area wide approach to both children and adult safeguarding issues and had good links with Dorset County Council, the Dorset Safeguarding Adults Board and Dorset Safeguarding Children Board and commissioners. In the year October 2014-September 2015,16 potential safeguarding concerns were referred to Adult Services, from both trust staff and external agencies. There were no external investigations under adult safeguarding procedures.
- In April 2015 the Clinical Commissioning Group issued a contact query as both adult and children's safeguarding training was well below target 85%. Compliance increased with the introduction of online training. By December 2015, 100% of staff had completed adult safeguarding training level 1 and 91% level 2. Compliance with children's safeguarding training, increased to 100% for Level 1, and for designated staff working with or around children 87% level 2, and 94% level 3.

Incidents

- Staff were encouraged to report incidents. The trust overall had a culture of safety where incidents were mainly appropriately reported and followed up. Learning was shared and changes made as a result of this to improve the safety of services. However, clinical safety incidents in anaesthetics (surgical services), had implemented a supplementary paper-based tool as well as the electronic reporting tool.
- The trust was reporting an overall similar amount of incidents per 100 patients to the National Reporting and Learning System (NRLS) as England wide, 8.4 per 100 admissions, 0.4% lower than the England average 8.8 per 100 admissions.
- The trust reported 4,130 incidents to the NRLS December 2014 – November 2015. The majority were low or no harm incidents. There were more no harm and severe harm incidents than

average and less low harm, moderate harm and death incidents. The majority of serious incidents had been for slips, trips and falls and pressure ulcers (grade 3 and 4).We found that incidents had been investigated through root cause analysis and the learning implemented.
- There were two never events reported in the trust, and 46 serious incidents between October2014 and September 2015.

Staffing

- The inspection team found staffing levels were not always sufficient to meet the needs of patients, particularly overnight. For example in surgery where there was often a ratio of one registered nurse to 14 patients at night, lower than the trust's stated plan of one registered nurse to eight patients.
- The trust undertook a daily review of nurse staffing and each month published planned and actual staffing on its wards. Staffing under 90% was highlighted to the board. Fill rates based on the agreed establishment in February 2016 were 97% for registered nursing during the day and 98% at night, and 98% for healthcare assistant staff during the day and 111% at night. However, this varied and there were wards with much lower fill rates (below 84% for registered nursing staff at times).
- Some wards had increased the number of beds and a high reliance on agency staff impacted on skill mix. Frontline staff on all wards reported that requests to fill staffing gaps, for example to cover for unplanned leave or sickness were not always filled.
- The nurse in charge of a ward was often required to provide nursing cover although they were not part of the nursing establishment. This meant they had reduced time to carry out their management and leadership roles.
- Therapy staffing levels were also insufficient. Between September 2015 and December 2015, the level of physiotherapists was consistently below target, at 45% to 90% variance. For example the respiratory physiotherapists did not provide a dedicated service to different departments, but worked in response to demand prioritising critical care patients.
- The trust had recently completed a review of acuity and dependency and required nursing and midwifery staffing levels(January/February 2016). The review had identified areas where nursing and midwifery and therapist staffing establishment needed to increase. The chief operating officer/ interim director of nursing told us this was in the annual financial plan due to be presented to the board.
- The trust had a higher proportion of junior doctors and consultants than the national average (31% compared with

Summary of findings

22% and 40% compared with 34%, respectively). There was a significantly lower proportion of registrar-group doctors, with 24% compared with 39% overall. Medical staff recognised this put pressure on medical staffing overall.

- The trust management team was fully aware of the shortage of registrars and in some services had added locum registrar posts to the rota. It was working with the local educational training board and other trusts and considering the development of middle grade posts, to improve the situation. Medical staffing in end of life care was not in line with national guidance.
- The vacancy rate for medical staff was 8.5%, and nursing staff 1.6%, but turnover rate for nurses was higher. The trust had an ongoing recruitment campaign.

Are services at this trust effective?

Requires improvement

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

Overall we rated the effectiveness of the services at the trust as 'requires improvement'. For specific information, please refer to the report for Dorset County Hospital NHS FT.

Evidence based care and treatment

- The treatment and care provided in most services took account of current evidence-based guidelines for the care and treatment of patients. However, maternity and gynaecology services did not always take account of current best practice guidance and polices needed updating. End of life care services had been slow to implement and embed latest best practice guidance.
- Services participated in national and local audits. There was appropriate monitoring of performance against national targets. However end of life care services had been slow to respond to the findings of care of the dying audits in 2014 and 2015.
- Most clinical services had an audit programme.Audits in most areas were prioritised based on national audits, or local issues.The majority of audits were being undertaken as planned and this was monitored.
- The trust reviewed NICE guidance to agree its use and to monitor implementation across services.
- Pain relief was given in a timely manner. Pain scores were used as part of the normal observations to record patients' pain and

to ensure that medicines for pain were effective. However, patient pain was not routinely monitored in critical care services or for patients who had difficulty communicating verbally .

- Patients nutrition and hydration needs were met appropriately. Patients who required intravenous fluids had these prescribed, administered and recorded appropriately.

Patient outcomes

- Most services participated in national and local audits which showed, overall, outcomes for patients as being similar or better than other trusts, for example gastroenterology and colorectal services. Orthopaedics outcomes were good, and the PROMS for hip replacement surgery was the best in the country. The treatment of major trauma patients through the trauma unit including the critical care delivery had been recognised as the best in the Wessex region.
- However, the trust had worse outcomes for stroke care. Results of 2104 and 2015 care of the dying audits were poor and implementation of actions for improvements in end of life care was slow and not consistently monitored. There was not a programme of audits for obstetric/maternity services.
- Mortality rates had been rising over the year and hospital standardised mortality ratio (HSMR) and standardised hospital mortality indicators (SHMI) were both higher than expected. The trust had recently investigated two mortality outlier alerts for specific conditions and identified some coding issues. A recent external review highlighted the increased mortality following admission on Sunday (HSMR 140) and Thursday (124). The medical director was leading a detailed investigation into all cases over the past 12 months.
- Mortality and morbidity meetings were held at departmental, divisional and trust level however the external review found that these were not standardised, with variation across divisions. The trust was taking action including creating a bimonthly Hospital Mortality Surveillance Committee, chaired by the medical director, to review all case notes of in-hospital deaths relating to the previous two months.

Multidisciplinary working

- Patients were cared for by multi-disciplinary teams working in a co-ordinated way collaborating to support patients with complex needs. Staff reported good working relationships and clear lines of clinical responsibility with specialist teams who were called to review patients.

Summary of findings

- The trust was an early implementer of seven day services. Many services had developed across seven days a week. However, there were not enough therapy staff to provide effective treatment to patients. Stroke inpatients also received significantly less physiotherapy than patients nationally.
- Wards held 'board rounds', to discuss further care or discharge arrangements for each patient; these involved consultants, therapists, a social worker and the sister in charge.
- The discharge team worked closely with each ward to assist with patients leaving the hospital. Patient transfer assistants liaised with staff on the busiest wards.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). They had access to advice and had completed training on MCA and DoLS. Guidance was available for staff to follow on the action they should take if they considered that a person lacked mental capacity. Notification of DoLS applications were correctly submitted to the Commission. A trust audit showed a high level of compliance with DoLS documentation, and any shortfalls were shared with the ward sister to rectify.
- Staff asked patients for their consent before providing care or treatment. The inpatient assessment form prompted staff to carry out mental capacity assessments if they felt patients might not have the capacity to make decisions or provide informed consent.

The majority of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were appropriately completed. Some areas still required improvement; discussion with the patient or relatives were not documented in patient records .

Are services at this trust caring?

Good

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

Overall we rated the caring provided by staff at the trust as 'good'. For specific information, please refer to the reports for Dorset County Hospital.

Compassionate care

Summary of findings

- We observed that staff were kind and compassionate, putting the patient at the centre of care. Patients and their relatives were positive about the caring attitude of staff, their kindness and their compassion.
- The Friends and Family test (FFT) results, showed on average 98% (96.5% - 99%) of patients completing the survey between December 2014 – November 2015 would recommend the hospital to family and friends. Overall, the trust consistently scored better and had a higher response rate, than the England average for the FFT.
- Data from national surveys for inpatients, cancer patient experience survey and the emergency department demonstrated that the hospital was similar to or better than other trusts. Patients were satisfied and would recommend the care they had received.
- Dignity and respect for patients was maintained at all times during treatment or examination. The trust's 'patient-led assessment of the care environment' (PLACE) audit score for privacy and dignity was 90%, above the national average of 86%.

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their treatment, understood their treatment plans and were able to make their own decisions They said they had been given personalised support, adapted to their ability to take on complex or emotional information.

Emotional support

- Patients and their families were supported by staff to reduce anxiety and concern. They felt involved in the decision-making process and had been given clear information about treatment options: they then felt enabled to ask questions of senior medical and nursing staff and be supported to make the decision that was right for them or for their loved one.
- The multi-faith chaplaincy service was available to provide emotional and spiritual support if requested. There was not a service for formal psychological support for critical care patients with complex emotional needs.

Are services at this trust responsive?

Overall we rated the responsiveness of the services at the trust as 'requires improvement'. For specific information, please refer to the reports for Dorset County Hospital.

Requires improvement

Summary of findings

Service planning and delivery to meet the needs of local people

- The trust operational plan described work to deliver against strategic aims of developing integrated care: putting patients first, developing workforce, engaging with GPs and the local health economy and clinical strategy. The trust was currently in the process of refreshing strategic and operational goals.
- The trust had identified the challenges and forward plans for: ensuring sufficient resilience to meet peaks in demand for admission: rising volumes of fast track referrals and pressure on outpatient slots, cancer diagnostics and treatment pathways, delayed transfers and impact on bed capacity, recruitment and retention in some clinical areas and delivery of cost improvement programmes. The plan identified increased activity in a range of elective and non elective activity. Outpatients procedures increased by 8.8% in line with the aim to provide treatment at the appointment and avoid the need for patients to return for treatment. There had been an increasing number of emergency admissions particularly among frail, elderly patients with respiratory conditions.
- The trust had invested in a range of initiatives to strengthen flexibility and alternatives to emergency admissions. These included the opening of step down beds and acute hospital at home. Delayed transfers and pressures on beds remained a challenge, the ambulatory care service had temporarily ceased through the need for additional escalation beds. The trust was undertaking joint work with the local community provider and local authority to reduce delayed transfers and had short term funding to pilot a 'discharge to access' scheme , and integrated assessment beds in a community hospital. There was a pilot of an extension of acute hospital at home, to include seven day a week rapid response domiciliary care for assessment and support up to seven days at home post discharge.
- There were some good examples and ongoing plans for joint working with GPs and local acute trusts in planning of integrated services and patient pathways. The trust provided locally based services including: Weymouth day surgery unit, renal home dialysis service, satellite renal dialysis units, an outreach respiratory service and community paediatrics.
- There had been development in cancer services and the provision of a dedicated cancer ward adjacent to the cancer outpatient treatment areas. The trust planned to extend its cancer radiography services to improve services to patients in Dorchester and West Dorset. There was an older persons assessment unit for multi disciplinary assessment and

treatment of the patient group, which makes up a significant portion of the local population. A range of business plans had been approved to meet the needs of patients, including the building of a second cardiac cath lab.
- Trust wide service planning and delivery was dependent on final decisions by commissioners following the Dorset Clinical Service Review. Some of the trust plans to address pressures were 'on hold' because of the Dorset Clinical Service Review, for example the expansion of the emergency department.

Meeting people's individual needs

- There was good support for people with a learning disability across services. There were robust processes for identifying and assessing patients, including a trust wide flagging system, admission protocol, assessment forms and use of the 'This is Me' care passport.
- The adult safeguarding lead nurse was lead for learning disability, there were plans to recruit a specialist learning disability nurse. Staff had access to information on the trust intranet and had attended training to help them support patients. There was a network of over 40 learning disability champions who were trained by speech and language therapists (communication) and the community learning disability team. The 'champions' contacted patients pre admission, held meetings to plan care, and held open days to familiarise patients with surgical services.
- Processes for identifying and assessing and planning for patients with a learning disability was regularly audited and reported to the board within the annual adult safeguarding report. This was a locally agreed CQUIN scheme. Audits throughout the year evidenced improvements in identification, timely assessment and adjustments made for patients with a learning disability. There was not a quarterly report to the board.
- All wards we visited provided care for patients in single sex accommodation bays, in line with Department of Health requirements. However, critical care mixed sex breaches were not reported if between 8pm and 8am.
- There were arrangements with the local NHS mental health trust to provide a liaison service for people with mental health disorders. The mental health team worked in the emergency department and inpatient areas.

- An interpreting service was available for people with communication or language difficulties. Staff were aware of how to access this. All information for patients was only available in English, this could be available in other languages or other formats if requested.

Dementia

- The national CQUIN outcome had financial incentives by the clinical commissioning group for achieving progress in the following key areas: to find, assess, investigate and refer:1. The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services.2. Clinical Leadership-Named lead clinician for dementia, dementia strategy, “This is me” promotion and appropriate training for staff. 3. Supporting carers-Supporting carers of people with dementia, including the provision of written information.
- Improving care for people living with dementia was a trust priority, and an improvement plan was discussed with matrons and geriatricians with the ambition for multidisciplinary and trust wide engagement. The trust had appointed dementia champions, but they were not in all areas across the hospital and some needed to attend level 3 dementia training. The trust had recognised areas for improvement including dementia screening and CQUIN performance, as reported to the board.
- The trust used the ‘This is Me’ booklet for patients living with dementia, developed by the Alzheimer’s Society to alert and inform staff to identify and meet the needs of these patients. We saw some patients living with dementia had ‘This is Me’ booklets, particularly if they were admitted from a care home.
- The Trust completed a programme of capital expenditure on its elderly care wards to ensure the environment was ‘Dementia friendly’. This involved removing nursing stations and remodelling facilities to reduce the potential for patients to fall or become confused by their surroundings.

Access and flow

- The trust was managing a high number emergency admissions and demand for services. The bed occupancy rate was higher than the England average. Bed occupancy was 95%, high when compared to the England average and recommended 85% and not below 90% since summer 2013/14. There were continuing challenges regarding access to care in the community, with an average 33 delayed transfers of care recorded per month. The

site management team provided a 24/7 service to support access and flow through the hospital, using an electronic tool. This helped them monitor and plan patient movements and estimated discharge dates. Site managers and the hospital discharge team worked collaboratively to maintain access and flow, with senior manager involvement when necessary.

- Performance in meeting national emergency access target for 95% of patients to be admitted, transferred or discharged from the ED within four hours was met or almost met through the year. The target was met for five out of the seven months between May 2015 to November 2015, with a drop to 92% in October 2015. Overall the trust performance between November 2014 and November 2015 was better than the England average. The four hour target was met for Q3 2015/16 at 95.4%, but in January 2016 this dipped to 92%.
- The trust reported 157 'black breaches' between December 2014 and November 2015. This is when ambulances are not able to hand over patients within one hour. A lack of physical capacity in the hospital was the main reported reason for this. The median times to both initial assessment and to treatment were lower than the England average.
- Between October 2014 and October 2015, 167 people attending the department waited between four to 12 hours from the decision to admit to hospital. The numbers were consistently well below the England average and had been decreasing since May 2015.No patients waited over the 12 hours target.
- There was an acute care hub to assist with effective patient flow and timely discharges.
- The trust used a bed management tool to monitor patient moves and aimed to move patients no more than three times during their admission. The trust aimed to avoid patient moves after 10pm however this was not monitored. We found patient transfers from the assessment unit often occurred at night.
- To maintain flow there was an average of 47 outliers a month (13% of beds). These patients were appropriately assessed, and there was a process to ' buddy wards' and ensure junior and senior medical staff from the relevant speciality reviewed medical outliers regularly.
- National standards detail that 92% of patients should start treatment within 18 weeks of referral for treatment. From May 2015 the trust had not met the 18 week incomplete pathway for referral to treatment (RTT) standard. General surgery 89% and trauma and orthopaedic and urology services (both 90%) almost met this target. In Q3 and January 2016 the trust reported the 18 week referral to treatment standard was met.

Summary of findings

- RTT for ophthalmology services was well below this target, with compliance rates of 73% over the year. The performance had improved since the summer 2015 and the target was expected to be met by the end of March 2016.
- The hospital's cancellation rate for operations varied slightly over the year but was similar to the England average. The percentage of patients whose operation was cancelled and who were not treated within 28 days was higher (worse) than the England average.
- In critical care, there were 40.8% of delayed discharges over 12 hours to wards due to lack of bed availability in the rest of the hospital, which meant patients could not be discharged to a ward at the earliest opportunity. This resulted in mixed sex breaches, which were not always reported.
- The trust wide bed occupancy rates for maternity and gynaecology were below England average. However, pregnant women did not consistently have prompt access to maternity services. The national and trust target of 90% for booking women for antenatal care by 12 weeks and 6 days gestation was met once between April 2015 –February 2016.
- The 24 hour paediatric assessment unit improved patient flow. GPs could refer children to the assessment unit, and following triage children were then admitted or they could return home. There was a system for recording waiting time within the assessment unit.
- The hospital delivered patient centred end of life care in a responsive and timely way . The hospital specialist palliative care teams assessed most newly referred patients within 24 hours.
- The trust operated a Rapid Discharge Home to Die (RDHD) pathway for discharge within 24 hours of patients who were thought to be in their last days of life and had requested to die at home. However, this was not monitored.
- The trust short notice cancellation rate for outpatient appointments was lower (better) than the England average. 'Did not attend' rates were also lower (better) than the England average and phone calls and texts were used to remind patients of appointments.
- There was variability in performance against some national cancer targets through the year. In January 2016 all the cancer standards were met with the exception of patients seeing a specialist within two weeks of an urgent GP referral and patients receiving their first definite treatment within 62 days of GP referral.

- The breast service was a one stop service that provided patients with a diagnosis and treatment plan within 14 days.
- Diagnostic wait times significantly improved since October 2014, to better than England averages. The trust reported the 6 week diagnostic standard was met in January 2016.

Learning from complaints and concerns

- There was a process and standards for handling formal complaints appropriately. and there was evidence of improvements to services as a result. The patient and public engagement lead staff understood how to manage complaints. The trust had been nominated for awards for implementation of best practice in complaints handling.
- All complaint responses were reviewed and signed by the chief executive. There were monthly overview reports to the Quality Committee and quarterly and annual reports to the trust board.
- Learning from complaints was disseminated across divisions via 'learning from patients committee' and a range of divisional clinical governance committees, team and professional meetings.
- During 2014/15 the trust handled a total of 385 complaints. This was a slight decrease in number when compared to the previous year (428).The trust explained this was due to increase in more timely local resolution, in line with trust policy and NICE quality standards. There was also a significant reduction in the number of complaints referred to the health service ombudsman since 2013.
- The most common complaint related to 'all aspects of clinical treatment', other common themes were outpatient appointments (delays or cancellations), communication,and staff attitude.
- Throughout 2015, complaints were not being responded to within the trust targets of 20 and 25 working days. The trust changed approach in February 2016 so that timeframes for response were negotiated with the complainant. There were early signs of improvement in the first few weeks; the aim was to reach the trust target of 95% of responses within agreed timeframes.
- Staff were unable to record informal concerns via the electronic reporting system, they emailed the central team to do this so there was a risk of under reporting. Any complaints identified as Duty of Candour issues were closed as complaints and opened as serious incidents and so not then counted as complaints.
- There was limited auditing or analysis of concerns for themes and trends from complaints. Complaints were not recorded as

Summary of findings

'upheld' or 'not upheld' and this was recognised as a barrier to analysis of resultant action and improvements. The trust was planning to introduce the complaints module on the electronic reporting system, to provide more accurate information and audit trails, however there had been delays in implementation.

- Patients were aware of how to complain or raise concerns; information was available across the trust. Staff followed trust policy to resolve concerns. Complainants were provided with the opportunity to feedback on their complaint experience, in line with national guidance and experience based design approach. All feedback was reviewed by the patient experience team.

Are services at this trust well-led?

Requires improvement

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

Overall we rated the leadership of the trust as 'requires improvement'. For specific information on the leadership of services, rated overall as 'requires improvement ', please refer to the report for Dorset County Hospital.

- The trust was in the process of reviewing its strategy, focusing on strengthening collaboration and partnership working with other organisations to deliver integrated and more sustainable services, with better outcomes and experiences for patients. The strategic goal was that Dorset County Hospital would become a leading integrated healthcare hub with a range of secondary and primary care services located on the site. The strategy and services of the trust would in part be determined by the outcome of the Dorset Clinical Services Review and the work of the Developing One NHS in Dorset Vanguard.
- There was a commitment to safe care and improving performance across the trust. The executive team recognised the need for a shift of focus to develop a culture of continuous quality improvement supported by a consistent governance framework. This had not yet been achieved and the board was not sufficiently informed about the improvements needed in some services, such as end of life care.
- Improvements were needed in the governance arrangements at the Trust. Recent external reviews confirmed that ward to board governance and reporting for trust wide assurance on quality

needed improvement. The senior management were using the findings and recommendations to develop, for example, a quality strategy, a governance framework, and an improved mortality review process.

- Progress and improvement against quality improvement projects was inconsistent across the trust. The trust identified that quality improvement training was needed within the leadership training programme, a key strand of the recently developed People Strategy.
- Trust wide staff had contributed to the recently developed set of values and behaviours to support the delivery of compassionate and safe care. Staff were positive about working for the trust and the quality of care they provided, many described the hospital as more than a place of work. They described a trust culture that was open and patient focused.
- The NHS staff survey demonstrated staff engagement was similar to trusts nationally. The trust had taken some actions to ensure black, Asian and minority ethnic groups had similar equal opportunities and career progression. Action was ongoing to improve this.
- There was a wide range of public engagement and involvement. The trust had developed innovative ways of engaging patients and obtaining feedback to improve services, including 'patient based experience' methodology.
- Cost improvement programmes were identified with clinical staff, and these were assessed and monitored to reduce the impact on quality and risk. However, expected savings had not been achieved in all areas and increased activity was contributing to costs and ability to make savings in the future. The trust was continuing with its financial recovery plan to reduce its financial deficit and would need to negotiate its current position under the national sustainability transformation plans.

Vision and strategy

- The trust vision wasto deliver compassionate and safe care. Its mission was 'working relentlessly to: deliver excellent healthcare, with high quality and safe outcomes,improved patient experience, providing value for money and learning from experience to improveservices'.
- The trust was in the process of refreshing its strategic plan in the context of its involvement in the ongoing Dorset wide Clinical Services Review and the Developing One NHS in Dorset Vanguard to integrate acute care.
- The CEO was specifically leading on the development of vertical integration across the acute, community and GP services,

delivered through five health hubs across West Dorset. The strategic goal was that Dorset County Hospital would become a leading integrated healthcare hub with a range of secondary and primary care services located on the site.

- The trust had developed five strategic improvement objectives:Outstanding services (quality and access); Collaborative working with partners across Dorset (Transformation); Integrated care pathways work with GPs (integration); Engaged staff and workforce fit for the future (capability and engagement); Sustainable financially(efficiency, value for money and productivity).
- The CEO told us clinical teams were involved in the development of strategic objectives and they would be involved in further work to identify the detail, key action plans and measures of success. The senior management team and board would use this work to further develop the strategy detail and governance framework.
- Some services had developed interim strategic plans or were developing greater integration within this context and staff were aware of local developments.
- The trust was in the process of developing a business intelligence strategy which was viewed as akey enabler to a quality improvement strategy in conjunction with the recent People Strategy.

Governance, risk management and quality measurement

- Trust governance arrangements included four sub committees of the board, the Audit Committee, Quality Committee, and Finance and Performance Committees. Below this was a CEO-led Senior Management Team (SMT) meeting, involving divisional leads, and a Clinical Governance Committee chaired by the Medical Director, mainly attended by medical staff.
- Ten committees reported to the SMT, which had responsibility for overseeing operational performance, business planning and risk management and reported to the executive directors meeting and Audit Committee (with integrated assurance role). Sixteen governance groups for example, infection prevention and control, safeguarding, clinical audit, drugs and therapeutics, reported to the clinical governance committee which reported to the Quality Committee and SMT.
- There was variability in the design and effectiveness of governance across different divisions and services. The trust had recognised ward/service to board reporting and assurance needed development. It had recently commissioned an

independent review of divisional and service level governance arrangements. A draft report, with recommendations was received in January 2016 and work on improvements had recently begun.

- The trust had started the process of identifying quality and safety priorities with key actions and clear measurable outcomes. The chief operating officer/ interim director of nursing was leading work on developing a quality improvement strategy and planned to present this to the board in summer 2016.
- There was not a trust wide performance and quality assurance framework providing comprehensive and timely information for monitoring service performance and informing service improvement. Information to the board was focused on monitoring compliance with national standards and targets and commissioning targets and reporting on quality was limited. The management information systems and reporting at divisional level was under-developed. The board were not sufficiently informed about the improvements needed in the services such as end of life care.
- Developing a quality improvement culture across the organisation, supported by a comprehensive governance framework, was recognised as a medium term risk in the integrated performance report to the board dated 9 March 2016.
- The trust were revising the governance framework to include better quality and safety metrics as part of the performance management of divisional teams. Work had started with five wards to develop a ward quality dashboard. This was being piloted at the time of inspection.
- The recent external review of mortality reporting also identified improvements were needed in the areas ofcoding, governance and reporting across divisions and to the board. Minutes of board meetings up to February 2016 showed the board had been monitoring Standardised Hospital Mortality Indicators (SHMI) and not the full range of mortality data. In response, a hospital mortality surveillance committee was being developed for in depth review of deaths and to provide assurance to the board.
- The risk management strategy had recently been revised from the 2011 version and was due to be presented to the Board in March 2016. The trust was developing the risk register on the electronic incident reporting system. Risk management policies and processes, facilitated escalation of risks from department to division to risk management committee. However, proactive analysis and management of risks was variable across divisions.

Summary of findings

The trust had taken some steps to improve risk identification at all levels. There had been a focus on ensuring the corporate risk register was better aligned with risks across the organisation. All levels in the process were asked to consider 'what needs to be escalated'. The risk register and scores were reviewed by the senior management team meeting prior to discussion at the Audit Committee. The corporate risk register presented to board in March 2016 contained much more detail on actions plans and accountabilities. However, although first identified as a concern in October 2015 rising mortality rates were not identified or discussed as a risk until February 2016 and were not on the risk register.

- The board assurance framework included strategic objectives and principle risks and identified key controls, sources of assurance, gaps in controls/assurance and actions for addressing gaps. These were RAG rated (rated red, amber or green, depending on the score) and regularly monitored. Several areas relating to quality and clinical services were amber. The most high risk, red rated concerns related to finance.
- The trust could not demonstrate improvements against all its quality improvement priorities. There was progress against some national and local clinical audits, but in some areas progress had been slow. For example, there had been work to improve identification of sepsis, part of the sign up to safety campaign, but the sepsis group was still identifying ways to audit its use.

Leadership of the trust

- There were some recent changes at board level. The current chair was appointed in late 2010.The focus at this time was to make improvements in financial governance as Monitor (now NHS Improvement) had found the trust to be in breach of its licence. The Chair was now 'stepping down' following two terms in the role and a new chair was starting in April 2016.
- The current chief executive officer (CEO) had been in post for just under two years, and had a previous role of chief operating officer at the trust. The medical director had been in post for nearly five years. Several executive directors had been in post a year or less. The chief operating officer had been in post less than a year and had taken on the dual role of interim director of nursing since December 2015. The trust was recruiting to the director of nursing role. The director of business and planning

was newly appointed. The tenure of the non-executive directors (NEDs) was predominantly two years with one in post over five years and one NED vacancy; the trust hoped to recruit a NED with clinical background.

- The NEDs predominately had a range of business and commercial experience, one had academic and clinical experience. We met three out of the five current NEDs as part of our inspection interview and focus group process. The NEDs we met described good communication and relationships with the trust executives. The NEDs had specific roles, for example, as audit committee or quality lead for the trust. There was an understanding of collective responsibility and support for board activities. The NEDs described a process of appropriate challenge and a team that worked together. There was recognition that the appointment of a new chair was an opportunity to look at board arrangements, trust governance structures and committees. Not all were clear about clinical risk and quality assurance and the recent review of divisional governance.
- The development of a quality improvement culture had recently been added to the strategic objective and the CEO and new Chair had agreed to hold board development days.
- The trust governors described excellent relationships with the trust leadership team. They had quarterly statutory meetings and had clear understanding of their role in holding NEDs to account, and several had nominated roles and sat on board committees. They were involved in all executive and NED appointments including trust Chair and CEO. The governors identified the leadership team as 'extremely approachable' providing good communication and an immediate response to concerns. They frequently undertook formal walkabouts in the trust and were able to assess and report on patient experience and staff views. They noted that under the CEO there was increasing focus on quality, innovation and development. They described the hospital as 'well run and well led'. Governors were able to advise on the trust's strategic direction and board appointments, hold the board to account, and participate in board programmes. They reported good patient and public engagement. Their only concern was the ongoing Clinical Services Review; some met with commissioners to raise concerns and ask for opinions from Royal Colleges on the proposals.

Summary of findings

- The NHS Staff Survey 2015 identified that the trust was about the same when compared to other trusts for staff reporting good communication between senior management and staff. Staff told us the leadership team were very visible, and were approachable and supportive.
- The senior team recognised the need to enhance its approach to training and appraising leadership and providing adequate support. The nursing leadership in some divisions needed to be strengthened.
- The leadership team showed commitment and enthusiasm to improving the quality and safety of their services and were open to inviting external review and scrutiny to assist with this. They were very committed to working effectively with partners in acute, primary and social care, to deliver appropriate services for local people. They were clear that effective working with partners would be the key to the transformation of services locally and across Dorset.

Culture within the trust

- Trust wide, staff and patients had contributed to the recently developed set of values and behaviours, the first priority in the recently published People Strategy. The values were launched in January 2016 with positive behaviours , 'the DCH way', and negative behaviours identified under four value themes: Teamwork, Respect, Integrity, and Excellence. These were designed to support the delivery of compassionate and safe care and an open and transparent culture. The trust had plans to apply the values to induction, appraisal, leadership development, staff and volunteer recognition.
- We found that these values were demonstrated by staff working in the hospital. Staff were positive and committed to them. One staff member told us, "the values articulate who we are, what we do and what we want to do". Many staff described the hospital as an important part of the community, a facility for friends and families.
- The NHS Staff survey 2015 identified that the trust was better than average for staff recommending the trust as a place to work or receive treatment, an increased score from the previous year.
- Staff were proud to work for the trust and the quality of care they provided. Many described the hospital as more than a place of work. Most staff described a trust culture that was open and patient focused.
- The trust had policies and procedures in place for whistle blowing and the contact numbers of independent, named NED were advertised around the hospital. Some staff we spoke with

were not confident in the whistle blowing process. The trust had not undertaken a formal, systematic review or benchmarking against the recommendations in the Francis review' freedom to speak up' report.

Fit and Proper Persons

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) to ensure that directors of NHS providers are fit and proper to carry out this important role.
- The trust followed the FPPR guidance and tool kit issued to NHS providers. A checklist was used to review all relevant documents
- There was not a specific FPPR policy in place, the process was detailed in an appendix of the recruitment policy, February 2016. This stated that continued assessment of continued fitness should be undertaken each year as part of the appraisal process. This was referenced as a prompt in the appraisal documentation to be used.
- A review of six files evidenced relevant checks and due diligence in the appointment ongoing compliance of executive directors.
- Checklists were complete in the files for non executive directors, but they did not contain references or the reference did not provide an opinion of character and suitability. In one file, qualification certificates were pending for an appointment made in 2014.

Public engagement

- Patient feedback was obtained through national surveys, the Friends and Family Test and comment cards. The hospital also worked with its local Healthwatch to obtain patient views.
- The learning from patients committee, a sub group of the clinical governance committee, was responsible for ensuring that feedback from patients and the public was used to continuously improve services and demonstrate improvements in practice.
- The trust had undertaken work to increase participation and feedback on the Friends and Family Test. There was a higher percentage response rate to the FFT (38.7%) than the national rate (33.7%) for the period July 2014 to June 2015.
- The trust encouraged patient involvement in co design and improvement of services using experience based design (EBD) tools. The ambition was to embed EBD across the hospital. At the time of our inspection, 40 departments had used EBD, for example it was used in developing the breast cancer service.

Patient groups were involved in the design ofthe new build and radiotherapy services, due to start in 2017 at the hospital. The trust was taking this experience of EBD to the Vanguard project. The trust was the lead for patient experience on the Dorset Cancer Alliance, and had a team of volunteer patient advocates.

- The CEO described the vision of the trust as providing more than secondary care, with the hospital as part of the 'fabric of the community'. There was a large team of volunteers working in a variety of roles across the hospital. The trust was working with Macmillan in mappingpatient information and setting up advice services in libraries. A local company sponsored lunch and activities at the hospital on Sundays and Christmas Day, for older people living alone in the community.
- The therapeutic environment at the hospital was greatly enhanced through the wide range ofsculpture, paintings, photographs, and music therapy, coordinated by the Arts in the Hospital team. The team worked with staff and local artists and also linked with local schools to arrange children's art exhibitions and involvement in the design of the hospital environment.

Staff engagement

- There was increased response to the NHS staff survey for the third year running; the 57% response rate for the 2015 survey was average when compared to similar trusts.The 2015 staff survey demonstrated improvement compared to 2014.The majority of scores were average, positive or better than other trusts.The trust had 10 negative indicators, lower than average, five of these werein the bottom 20% of trusts.These were: staff satisfaction with the quality of their work and patient care they are able to deliver, agreeing that their role makes a difference to patients, experiencing physicalviolence from staff in the last 12 months,fairness and effectiveness of procedures for reporting errors, near misses and incidents.Action was being taken in response to the areas that required improvement.
- The quarterly staff Friends and Family test,'DCH pulse check' Q3,identified that 59% of staff would recommend the trust as a place to work (the England average was 62%) and 80% of staff would recommend the trust as a place to receive care (the England average was 79%).
- A review of medical staff engagement at the trust in November 2015, reported high relative engagement with scores for having purpose and direction rated as highestrelative engagement score. Medical staff in management positions and consultants were more engaged than specialty/staff grade or associate

specialists. Senior managers appeared to strongly underestimate medical staff ratings on having purpose and direction. Areas for further investigation and work were identified for the trust to take forward.

- The workforce race equality indicators (April 2015) demonstrated 7% of staff, and 11% of senior and very senior managers, had a black or minority ethnic (BME) background. This compares to the wider population of Dorset in which 2.1% are from BME backgrounds. White staff were more likely enter formal disciplinary procedures and BME staff were 1.4 times as likely to access non mandatory training and CPD.However, white candidates were 13% times more likely to be appointed for a job role than a BME candidate.In the staff survey, BME staff responded 5% more favourably regarding relevant training, learning and development did experienced less harassment, bullying or abuse from patients or public.However, more BME staff identified they experienced harassment, bullying or abuse from staff, and discrimination from colleagues and fewer believed the trust provided equal opportunities for career progression or promotion. The trust board had the expected representation; 8% were from a BME background. The trust had identified actions and was setting up a BME staff network to explore and take forward the issues and would implement the Equality Delivery System in partnership with the Dorset Equality and Diversity Network.
- The resultant Equality Delivery System report identified the trust was 'achieving': fair NHS recruitment and selection processes; equal pay for work of equal value; training and development opportunities taken up and positively evaluated by staff; flexible working options; positive experience of their membership of the workforce; board and senior leadership demonstrate commitment to promoting equality and middle managers and line managers support staff to work in culturally competent ways.It reported a range of protected characteristics fared well on all these questions, including race.
- Many staff we spoke with, particularly in the clinical teams, were positive about working for the trust, and were positive about the quality of care provided.Staff were positive about the leadership of the trust management and identified a collaborative, flexible working style with the trust leadership team.Staff discussed the open and transparent communication style within the trust and the supportive attitude, overall, of managers and leaders. The exception was the maternity and

gynaecology service where consultants did not all work well as a team and working relationships were strained. In some areas, managers were under pressure to work clinically and were then not able to complete all aspects of their role.

- The trust leadership team held open engagement sessions with staff about the Dorset Clinical Services review and the Vanguard project. Trust wide staff were involved in discussions about trust values and behaviours. Senior staff were invited to away days to discuss the developing clinical strategy. The CEO sent weekly email bulletins and held monthly team briefs.
- The trust presented annual awards which highlighted staff who provided exceptional care, support or customer service over the previous year. Staff were nominated by the public and were acknowledged for going ' above and beyond' to ensure patients received the best care and experience possible.

Innovation, improvement and sustainability

- Staff were being encouraged to innovate and improve services, through quality improvement, operational developments, clinical audit and research. The trust encouraged departments to enter for awards and the hospital was in the benchmarking services 'Capse Healthcare Knowledge Systems' (CHKS) 'Top Hospitals' in 2015, for third year running. However achieving quality improvement priorities; CQUINs, quality account priorities and sign up to safety priorities, were identified as a key risk by the trust.
- Improvement in outpatient services was also identified as a key risk by the trust and there was ongoing work on the o that was starting to have an effect. There was further work to achieve a fully functional ambulatory care and assessment unit and an ongoing plan to fully implement 'hospital at night'. The Vanguard project provided an opportunity for Dorset wide workforce planning and finding solutions to the challenges in sourcing and recruiting appropriately skilled and competent staff.
- The trust forecasted a year end deficit position of £5.4m for 2015/16, this was greater than a target of £3.5m. The main issues leading to this deficit were identified as staffing costs, escalation beds and increased ophthalmology activity to address waiting times. Financial sustainability and cost improvement programmes (CIPs) were the highest rated risks on the corporate risk register.
- CIPs focused on efficiency savings and better procurement through enhanced budget control within directorates, increases

in income opportunities, and reducing agency expenditure.A trust wideBetter Care Better Value group had been established to support divisions in the identification and achievement of savings.

- All CIPs had a quality impact assessment at divisional and trust level. This included sign off by the medical director and director of nursing. CIPs were monitored through quarterly performance meetings and more regularly if needed. The forward plan was that CIPs would link in with new 'balance score cards' to provide more detailed assurance of impact.
- The trust had been offered additional national funding from the Sustainability and Transformation fund for 2016/17, but the linked required out turn for 2016/17 was not considered achievable. The trust was discussing its present position with its clinical commissioning group and NHS Improvement. The trust's long term sustainability was anticipated to be resolved through the NHS Dorset Clinical Services Review and the 'One NHS in Dorset' Acute Care Collaboration Vanguard project and work to integrate acute and community services in the west of the county**.**
- The trust's performance was reviewed by the health regulator Monitor, part of NHS Improvement from 1 April 2016.The trust's financial sustainability risk rating was '2'.The rating was based on the risk that the trust could fail to carry on as a going concern. A rating of '1' indicates the most serious risk and '4' the least risk. A rating of '2' means the trust's financial position is unlikely to get worse in the immediate future. The trust governance rating was under review, with more information being requested following a deterioration in the trust's financial position.

Overview of ratings

Our ratings for Dorset County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Dorset County Hospital NHS Foundation Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

- The hospital@home service provided a valuable service supporting medically fit patients to have earlier discharges to their homes. This service was provided 24/7 and helped improve access and flow in the hospital as well as improving outcomes for patients.
- The support for renal dialysis patients was outstanding, with individualised care for patients to receive home dialysis and holiday dialysis when appropriate and safe.
- The genitourinary medicine service was a well-led, patient focused service that had identified the needs of the patient groups it served, many of whom were vulnerable. There was excellent multi-disciplinary working with external agencies and robust clinical standards in place, which the service audited themselves against, always looking for how they could improve the service. Outpatient clinics and advice sessions were held, where possible, at venues that encouraged attendance from patients who had the greatest need for the service but could not, or found it challenging to, attend a hospital.
- The two bereavement midwives made home visits following a stillbirth or neonatal death. They made follow up visits to tell the parents post-mortem results in person and offered to provide antenatal care for women in any subsequent pregnancy. They also set up the monthly 'Forget Me Not' bereavement support group in a local children's centre. They set up and closely monitored a private social media page for women who had lost a baby during pregnancy or after birth.
- A gynaecology specialist nurse ran the 'Go Girls Support Group' along with a former patient, to provide support for women diagnosed with a gynaecological cancer.
- Midwives ran specially designed antenatal, breastfeeding and smoking cessation sessions for 'Young Mums'. They were also offered separate tours of the maternity unit.

- There were several examples of patient involvement in the and improvement of services and excellent use of experience based design (EBD) methodology

Areas for improvement

Action the trust MUST take to improve

The trust **must** ensure:

- All equipment is clean and fit for purpose and ready for use in the emergency department. A clear process must be implemented to demonstrate the mortuary trolley has been cleaned, with appropriate dates and times recorded.
- The five steps to safer surgery checklist is appropriately completed.
- The management and administration of medicines always follows trust policy.
- Patients in the minor operations room (used as a majors cubicle) in the emergency department have a reliable system in place to able to call for help from staff.
- There are sufficient therapy staff available to provide effective treatment of patients.
- The numbers of nurses on duty are based on the numbers planned by the trust all times of the day and night to support safe care.
- Sufficient palliative care consultant staffing provision in line with national guidance and to improve capacity for clinical leadership of the service.
- The number of midwives is increased according to trust plans and in line with national guidance, to support safe care for women.
- Staff complete mandatory training updates.

Outstanding practice and areas for improvement

- Turnaround times for typing of clinic letters are consistently met, monitored and action taken when targets are not met across all specialities within the trust.
- All patient records must be stored securely to maintain patient confidentiality
- Risk registers at local, directorate and divisional level are kept up-to-date, include all factors that may adversely affect patient safety and progress with actions is monitored.
- There are clear and measurable action plans for improving patient outcomes with regard to service targets and key performance indicators, as measured in the National Care of the Dying Audit.
- Care and treatment in all services consistently takes account of current guidelines and legislation and that adherence is audited.
- Consultants supervise junior registrars in line with RCOG guidance.
- Continued development of governance processes across all specialties and divisions, with a standardised approach to recording and reporting.The trust must ensure the information is used to develop and improve service quality.
- Regular monitoring of the environment and equipment within the emergency department and that action is taken to reduce risks to patients.
- Mixed sex breaches in critical care must be reported within national guidance and immediately that the breach occurs.
- Improvements in the environment of the critical care unit, taking into account the guidance set out in HBN 04-0 and views of stakeholders and commissioners.

The trust should ensure:

- There are quarterly reports to the board on progress against implementation of standards for patients with a learning disability.
- There is formal, systematic review and benchmarking against the recommendations in the Francis 'freedom to speak up' report.
- Recommendations from the external mortality review are implemented.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 Health and Social Care Act 2008 (Regulated activities) Regulations 2014 Safe care and treatment** Regulation 12(1)(2)(b)(c)(g)(i) **How the regulation was not being met:** • Nationally recognised best practice guidance was not always followed in obstetrics and gynaecology. • Medicines were not always managed safely and in line with current regulation. • The 'Five steps to safer surgery' checklist was not always fully completed • Consultants did not always supervise junior registrars in line with Royal College of Obstetricians and Gynaecologists' guidance. • There were delays in clinic letters being typed and sent to GPs in a number of specialities, including cardiology, haematology and dermatology. Delays ranged from five to nine weeks. There was a clinical risk to patients as GPs were not aware of changes to treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment** Regulation 15 (1)(a)(b)(c)(e)

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- Suitable arrangements were not in place in relation to infection control procedures and maintenance of the mortuary trolley.
- Patients in the minor operations room in the emergency department had no means of calling for assistance.
- Equipment in the emergency department was damaged and in some incidences had not been cleaned.
- There was damage to the fabric of the environment of the emergency department.
- There was not a patient call bell system in all treatment areas used as cubicles in the emergency department.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health and Social Care Act 2008 (Regulated activities) Regulations 2014 Good governance Regulation 17 (1)(2)(a)(b)(c)

How the regulation was not being met:

- Patients' records were not complete and contemporaneous due to delays in clinic letters being typed. Information relating to decisions on care and treatment was not always available.
- There was a secondary information governance risk as patient records were not stored securely in all areas of the hospital.
- Governance processes to assess, monitor and improve service quality were not consistently used and embedded across departments, directorates and divisions.
- There were insufficient systems to assess monitor and improve the quality of the EOLC services provided.

This section is primarily information for the provider

Requirement notices

- There was not systematic monitoring of all equipment and the environment in the emergency department, to identify and manage risks to patients.
- Risk registers were not all kept updated to reflect all factors that might adversely affect patient safety, with actions to mitigate risks.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing Regulation 18 (1) (2)(a) **How the regulation was not being met:** • There was insufficient medical cover, at consultant level, for end of life care services across the hospital. • There were not always enough nursing, midwifery, therapy and medical staff with the right skill mix to provide safe care. Staffing levels had been reviewed, but changes to staffing levels identified as necessary from the reviews had not been fully implemented at the time of the inspection. • There were not sufficient medical staff on the neonatal unit at all times, including overnight. • There was low compliance with mandatory training updates in some staff groups.