The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Christchurch Hospital

Quality Report

Fairmile Road
Christchurch
Dorset
BH23 2JX
Tel:01202 303626
Website: www.rbch.nhs.uk

Date of inspection visit: 20 - 22 October 2015
Date of publication: 25/02/2016

This report describes our judgement of the quality of care at this hospital. 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 hospital	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Christchurch hospital is the smaller of two hospitals provided by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The trust gained foundation status in 2005 and provides services, to a population of 550,000 in the Dorset, New Forest and south Wiltshire areas, which rises in the summer months due to an influx of visitors to the area.

We inspected the trust, Royal Bournemouth Hospital, and Christchurch Hospital as part of our comprehensive inspection programme.

Christchurch Hospital provides end of life care services including, the Macmillan Unit with 16 inpatients beds, a specialist palliative care centre and a community palliative care team. There are a range of outpatient clinics including children's dermatology out patients, and an x-ray service. There is a large day hospital providing rehabilitation services.

We inspected two core services at Christchurch Hospital: end of life care; and outpatients and diagnostic imaging. We also inspected children's outpatient dermatology service and detailed findings are within the Royal Bournemouth Hospital location report under children and young people's core service.

No other services are provided at Christchurch Hospital.

We carried out an announced inspection visit to Christchurch Hospital 20 -22 October 2015. The inspection team included CQC inspectors, specialist palliative and end of life care nurse, speciality doctor in palliative medicine, consultant geriatrician, respiratory physician, physiotherapist, radiographer, paediatric nurse, and experts by experience.

We rated Christchurch Hospital as 'good' overall and good for providing safe, effective, caring responsive and well led end of life care services, and outpatient and diagnostics services.

Our key findings were as follows:

Are services safe?

- There were reliable systems and processes in place to support the delivery of safe care and treatment.
- Staff were aware of their responsibilities to report incidents and there was evidence of learning from incidents.
- There were two never events in dermatology outpatients in the 12 months to April 2015, these had been thoroughly investigated with processes and practices changed as a result.
- In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the Care Quality Commission.
- The hospital site was undergoing a major re-development and refurbishment programme. Environmental risks had been assessed and mitigations put in place to ensure safety was not compromised.
- Patient clinical areas were visibly clean and staff followed infection control policy and practice.
- Records were well completed and generally stored securely.
- Staffing levels were adequate in all areas, with recent recruitment to meet additional demand on end of life care services. There were appropriate arrangements for out of hours cover.
- Staff had a good understanding of safeguarding adults and children. Safeguarding was given sufficient priority and staff took a proactive approach to the early identification of safeguarding concerns.
- Medicines were appropriately managed and stored in most areas, however oxygen was not stored in appropriate holders in the Macmillan Unit. Patient group directions (PGD), which allow trained non-prescribers to administer medicines without prescription, were mostly in date.
- Equipment was serviced, checked and stored appropriately.

Summary of findings

- Mandatory training for staff in end of life care services was below target. Compliance with mandatory training was high for outpatient and diagnostic imaging services.
- Patients were assessed and monitored appropriately. In end of life care services there were arrangements to minimise risks to patients including falls, and pressure ulcers. Staff demonstrated a good understanding of the early identification of a deteriorating patient.
- Staff generally had a good understanding of the Duty of Candour and their roles and responsibilities in applying it to their everyday practice.

Are services effective?

- People's care and treatment was planned and delivered in line with current evidence based practice. A new personalised end of life care plan was in use following the withdrawal of the Liverpool Care Pathway.
- There was evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in outpatients. Local audits were undertaken in outpatients and diagnostic imaging
- Patients had appropriate access to pain relief. Anticipatory end of life care medicines were appropriately prescribed for symptom control and patients were provided with pain management support.
- Patient nutritional needs were met, with dietetic support if required. The nutritional status of most patients was assessed prior to admission to the Macmillan unit. There were plans for assessment of all patients on admission.
- There was effective multidisciplinary working across the Christchurch hospital site and the Royal Bournemouth Hospital and continuity of care with GPs and community staff. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Most staff had received an annual appraisal although there had been some delays due to a change in the appraisal system in 2015. Staff felt able to access relevant training to update their clinical skills specific to their roles.
- Staff were appropriately qualified, with access to a comprehensive training programme for end of life care.
- Patients had access to seven-day services, as required.
- Most staff had a good understanding around consent procedures and there was good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests
- Most 'do not attempt cardiopulmonary resuscitation (DNACPR) forms' were appropriately completed.

Are services caring?

- Staff treated patients with compassion, kindness, dignity, and respect.
- Feedback from patients and their families was consistently positive for all services.
- The latest Friends and Family test results showed that 97% of patients completing the survey agreed that they would recommend the hospital to family and friends.
- Patients and their families were respected and valued as individuals and were empowered as partners in their care.
- Staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.
- All staff demonstrated a commitment to providing compassionate care not only to patients but also to their families and post bereavement.
- Chaplains and staff provided emotional support to patients and relatives. A team of volunteers had been trained to provide additional support for patients receiving end of life care
- Outpatient department staff provided emotional support and used quiet rooms to speak with patients who had been given bad news.

Are services responsive?

- Services were planned and delivered in way which met the needs of patients, and the local population.

Summary of findings

- There was an overarching development plan for the hospital site. This included refurbished facilities and development of existing services and working with partner organisations to create additional primary and social care services to meet the needs of the local population.
- There was good access to outpatient and diagnostics clinics, with Saturday clinics held for certain specialties. Patients told us that there was good access to appointments and at times which suited their needs. Patients reported clinics generally ran to time.
- From October 2014 to June 2015, the trust achieved or exceeded the referral-to-treatment (RTT) standard of 92% for patients waiting less than 18 weeks from referral to treatment (incomplete pathways) in every month.
- There were delayed discharges from the Macmillan Unit that were impacting on timely admission of patients, this was recognised and was being addressed at board level.
- Action was taken to meet the increasing number of referrals to the specialist palliative care community team
- Despite on-going building works in and around the hospital patients commented on the pleasant environment and the atmosphere within the hospital. The hospital was accessible for patients in wheelchairs.
- There was no signage available for patients who did not speak English as their first language and no information leaflets were available in any other languages. An interpreter service was available trust wide, which was booked once staff were aware of patient requirements.
- Service received very few complaints and concerns. Those that had been received had been resolved locally and informally and changes made as required. The Macmillan unit received many commendations.

Are services well led?

- The trust had an overarching strategy for the development of service at the Christchurch hospital site. Also staff were generally aware of the vision and values of the trust to be the most improved hospital in the UK by 2017 and to provide excellent care as they would expect for their families.
- The 2020 strategy for diagnostic imaging was being planned with staff engagement in moving the strategy forward.
- The end of life care strategy, based on achieving full compliance with national guidelines, was created in response to the inspection. Although it reflected much of the vision and ongoing work of the end of life steering group, it had not been subject to consultation or presented at trust board level.
- The services at the hospital were well led locally, staff felt supported and worked in an integrated way across teams and services. Staff in all areas told us their manager was visible and approachable and they felt well supported and valued.
- There were governance structures within the services and systems for identifying, assessing and managing risk, and monitoring quality and performance.
- There was an open culture and staff felt they could make suggestions to improve service for patients. Feedback was actively sought from patients. The day hospital held patient focus groups where patients and their representatives could put forward suggestions for changes and improvements to the service.
- The palliative medicine consultants and community specialist palliative care service were working to continually improve the quality of end of life care across the trust.
- Some staff felt distant from the Royal Bournemouth Hospital and reported a lack of visibility of the trust executive team at the Christchurch hospital site.

There were areas of practice where the trust needs to make improvements.

The trust should ensure:

- There is consultation on the overarching end of life strategy, with internal and external stakeholders.
- Where relevant, mental capacity assessments are completed on the DNACPR forms.
- All policies within end of life care service are reviewed and updated as planned.
- A formal clinical audit programme is put in place at the hospital.
- Staff appraisals are completed, to reach trust targets.

Summary of findings

- Staff complete mandatory training, to reach trust target levels.
- Nutritional screening is completed for patients on admission to the Macmillan unit.
- Medical records are stored more securely, in locked trolleys and /or secure offices to prevent unauthorised access.
- Timeliness of communication between end of life care services and the district nursing team.
- Documentation of the efficacy of pain relief given to patient in end of life care.
- Monitoring of all a patients with a delayed discharge is reviewed.
- Oxygen cylinders stored in a location on the Macmillan unit where they are not a trip hazard.
- Review the processes in place for monitoring the fridge temperature in the mortuary.
- Improve the general decoration of the mortuary viewing room, if it continues to be used.
- Review notice boards throughout outpatient departments at Christchurch Hospital to ensure clear and consistent information is provided.
- Trust senior management are more visible at Christchurch Hospital.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
End of life care	Good	People were protected from avoidable harm and abuse. There were reliable systems and processes in place to ensure the delivery of safe care. Nursing and medical staffing levels supported safe care and treatment. There were appropriate arrangements for out of hours cover. Following the withdrawal of the Liverpool Care Pathway, the trust had introduced new personalised end of life care plans. This care plan, entitled 'personalised care plan for the last days of life', had been piloted at the Royal Bournemouth Hospital and, since August 2015, was in use at the Macmillan unit. There was good multidisciplinary working, staff were appropriately qualified, and had good access to a comprehensive training programme dedicated to end of life care. We observed a person-centred culture. Staff involved patients in their care and treated people with compassion, kindness, dignity, and respect. Feedback from patients and their families was consistently positive. People's needs were mostly met through the way end of life care was organised and delivered. The rapid discharge service for discharge to a preferred place of care was responsive to the needs of patients and their families.The trust board were aware of an issue with delayed discharges. Delayed discharges affected timely admissions for all appropriate patients. There had been recognition of an increasing number of referrals to the specialist palliative care community team and action taken. The trust proposes in 2017-2018 to replace the existing specialist palliative care unit with a new expanded facility supported by Macmillan Caring Locally. There was no end of life care strategy in place at the time of our inspection. During our inspection, the trust created an overarching strategy for end of life care with the aim of achieving full compliance with national guidelines. The medical director represented end of life care at board level. The associate medical director championed and supported end of life care. There was an end of life steering group that met monthly to monitor performance against national standards.

Summary of findings

The specialist palliative care service based at the Macmillan unit was well led and worked in an integrated way across teams and services, with a governance structure and speciality risk register in place. The Macmillan unit and community specialist palliative care team mutually respected each other, and encouraged staff and public involvement. Colleagues at the Royal Bournemouth Hospital, also valued the support and advice provided by staff from the unit.

The palliative medicine consultants and community specialist palliative care service were working to continually improve the quality of end of life care across the trust.

Outpatients and diagnostic imaging	**Good**		We rated the outpatient and diagnostic imaging services at the hospital as “good” overall. All areas were given ratings of good for safe and caring services. We found them to be good at providing responsive and well-led care. At the time of inspection the Christchurch hospital site was undergoing a major re-development and refurbishment program. As a result some outpatient clinics and services had been temporarily relocated around the site whilst work was carried out. This caused disruption to both patients and staff. We observed that risks had been assessed and mitigations put in place to ensure safety was not compromised. For example, a fence had been placed around the temporary radiology building to provide an exclusion zone. All staff and building contractors had been briefed about for the exclusion zone and the reasons not to cross the fence. The day hospital, outpatients and diagnostic departments were well-organised and visibly clean, and there was no shortage of necessary equipment. Medicines were appropriately managed and stored. There was evidence of effective multidisciplinary working across the Christchurch hospital site, the Royal Bournemouth Hospital and GPs. Services were planned to meet patient needs. Patients told us there was good access to services and appointments and at times that suited their needs. Staff demonstrated they were passionate about caring for patients and clearly put the patient’s needs first, including their emotional needs. Our observations were that staff provided a strongly patient-centred focus to their work, no matter how busy they were.

Summary of findings

Staff were caring and compassionate and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been actively involved in decisions about their care. There was an interpreter service available for patients whose first language was not English. However, there was no literature immediately available in other languages or other formats, such as large print, unless requested. Staff spoke positively about the leadership at a local level and the visibility and support of the senior team. Although staff did also mention the lack of visibility of the trust executive team at the Christchurch hospital site.

There was an open culture and staff felt they could make suggestions to improve service for patients. Feedback was actively sought from patients.

Christchurch Hospital

Detailed findings

Services we looked at
End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Detailed findings from this inspection

	Page
Background to Christchurch Hospital	10
Our inspection team	10
How we carried out this inspection	11
Facts and data about Christchurch Hospital	11
Our ratings for this hospital	13

Background to Christchurch Hospital

Christchurch hospital is part of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The trust gained foundation status in 2005. It provides services, to a population of 550,000 in the Dorset, New Forest and south Wiltshire areas, which rises in the summer months due to an influx of visitors to the area.

Services at Christchurch Hospital are accessed by patients across both Bournemouth and Christchurch districts. These districts are in the 4th and 2nd quintiles of the 2010 English Indices of Deprivation respectively – where the 1st quintile is the least deprived.

The hospital currently provides end of life care services including, the Macmillan Unit with 16 inpatients beds, a specialist palliative care day centre and a community palliative care team. There are a range of outpatient clinics including children's dermatology out patients, and an x-ray service. There is a large day hospital providing rehabilitation service. A major redevelopment programme is underway, which will provide refurbished facilities for these services. At the time of inspection work some of the outpatient and x-ray departments were in temporary accommodation.

The trust has closed outdated nightingale wards and departments at the hospital and is partway through a major redevelopment of the Christchurch Hospital site. This work is being undertaken with partner organisations and will support the development of additional primary and social care services to support the local population, with a high proportion of older people.

We inspected the hospital as part of our comprehensive inspection programme. We inspected two core services at the hospital which are detailed in this location report: end of life care and outpatients and diagnostic imaging.

We also inspected children's outpatient dermatology service.and detailed findings are within the Royal Bournemouth Hospital location report under children and young people's core service.

Our inspection team

Our inspection team was led by:

Chair: Bronagh Scott, Deputy Chief Nurse, NHS England London

Head of Hospital Inspections: Joyce Frederick , Care Quality Commission

The team that inspected this location included a CQC manager, CQC inspectors, specialist palliative and end of life care nurse, speciality doctor in palliative medicine, consultant geriatrician, respiratory physician, physiotherapist, radiographer and experts by experience.

We carried out an announced inspection visit to Christchurch Hospital 20 -22 October 2015.

Detailed 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 Christchurch Hospital 20 -22 October 2015

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

We held stalls and listening events at a library, shopping centre, leisure centre and an evening meeting Bournemouth on Wednesday 7 October 2015. People shared their views and experiences of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

At the inspection we conducted focus groups and spoke with a range of staff in the trust and the hospital, including nurses, 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 patients and staff from all areas of the hospital, and accompanied palliative care team on a home visit. We observed how people were being cared for and talked with carers and/or family members and reviewed 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 the Christchurch Hospital.

Facts and data about Christchurch Hospital

Christchurch Hospital is part of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The location hosts the day hospital, which offers specialist assessment, treatment and rehabilitation for the elderly, and the Macmillan Palliative Care Unit. There are a number of outpatients' clinics that run from Christchurch, namely Dermatology, Rheumatology and Pain Management.

There are 16 inpatient beds at this hospital, and in 2014-15 there were 9,125 bed days

There is a population of approximately 550,000 people in the Dorset, New Forest and south Wiltshire areas, which rises in the summer months due to an influx of visitors to the area.

As at 31st October 2015 the hospital had a total of 166.5 Whole Time Equivalents (WTE) in post inclusive of nursing staff, medical staff, other clinical staff and non-clinical staff. The bank or agency staff usage for Christchurch Hospital the period of Nov'14 –Oct'15 was 8.19%.

1. Safety

There was one never event at Christchurch Hospital and three serious incidents (SI) reported between July 2014 and August 2015. This never event involved a wrong site surgery in the outpatients dermatology clinic. Two of the three SI were pressure ulcers and the other a patient fall all occurring on the Macmillan unit.

There were 370 events reported to the National Reporting and Learning System (NRLS) in February 2014 – January 2015 for Christchurch Hospital, of which 2 (0.5%) caused severe harm to the patient.

Number of incidents

Deaths

0

Severe harm

2

Moderate harm

Detailed findings

7

Low harm

120

No harm

249

In the last financial year Christchurch Hospital has had two cases of C Diff, none of these were trust acquired the patients were admitted with the infection. The trust policy for MRSA, in line with the new report would only require patients who were previously positive for MRSA to be screened. There have been no cases of Trust acquired MRSA[1] bacteraemia in the trust since Aug'13.

There is only one inpatient ward at Christchurch Hospital and therefore only one ward submitting data into the safety thermometer. Data from the Patient Safety Thermometer showed that there were 0 Falls with Harm, 15 new pressure ulcers, and two cases of catheter-acquired urinary tract infections (CUTIs) between July 2014 and July 2015.

2. Effective (trust wide)

The majority of the inpatient beds at the Christchurch Hospital part of the Trust were closed more than five years ago, leaving the palliative care unit, otherwise known as the Macmillan Unit, as the only inpatient facility on the Christchurch site. The 16 beds at Christchurch Hospital's Macmillan Unit have a relatively high crude mortality rate as expected given the palliative remit. Although there is a correction for palliative care in statistical analysis that produces the Hospital Standardised Mortality Ratio (HSMR) figure, this does not adequately recognise the palliative remit. The HSMR for Christchurch Hospital in June 2015 was 181.8 and for July was 139.0. These figures are both higher than the planned figure of 100.

The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at Trust level across the NHS in England and therefore is not available at site level. However, the SHMI was within the expected range for weekdays and weekend admissions for the Trust as a whole during October 2013-September 2014.

There were no mortality outliers in this trust and therefore this site in 2014/15.

3. Caring (trust wide)

The CQC inpatient survey is only reported at trust level and therefore there is no data available specifically for Christchurch Hospital.

4. Responsive (trust wide)

In 2014/215, this trust received 10 formal complaints for Christchurch Hospital six of which related to the outpatients department, two related to both Dermatology and Rheumatology.

The dermatology department sees patients with skin cancer. For Quarter 1 2015-2016, 99.5% of cancer patients were seen by a specialist within two weeks of an urgent GP referral, which is above the operational standard of 93 %. For both 31 days from diagnosis to first definitive treatment and 62 days from diagnosis to first definitive treatment, the patients could be referred from the dermatologist to a surgeon for excision. Without checking back through each individual patient it is not possible to emphatically say what is at Christchurch Hospital and what is at Bournemouth. However, the proportion of patients waiting less than 31 days from diagnosis to first definitive treatment was 98.6% for skin cancer patients, which is above the standard of 96%.

5. Well led

There are 166.54 WTEs working at Christchurch Hospital. The numbers of staff by staff type are given below

FTE	
Nursing Staff	56.64
Medical Staff	15.30
Other Clinical Staff	48.32
Non-clinical Staff	46.28
Total	166.54

(NB: Non clinical staff includes all staff on 'XN' Payscale, other clinical staff includes all staff on 'XR' Payscale excluding nurses, Nursing staff includes staff group nursing and midwifery registered and Medical staff includes staff group Medical and Dental.)

Staff sickness levels in this hospital site were 4.6% and there was a turnover rate of 10.8% for the period of 1st December 2014 to 31st October 2015.

Detailed findings

The staff survey results are only reported on trust level rather than site level therefore there is not any specific data for Christchurch. However the results from the staff survey in 2014 showed that the trust as a whole performed in the top 20% of trusts for four key findings, and in the bottom 20% of trusts for one key finding. For the remaining 24 key findings analysed, the trust's results were in the middle 60% of all trusts. The response rate in this trust was 49% (higher than the England average of 42%, but below the rate in 2013 – which was 55%).

A detailed breakdown of some of the staff survey questions is given below:

All White BME Difference

KF18 - Percentage of staffe experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months*

30% 31% 37% 6%

KF19 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

25% 24% 33% 9%

KF28 - In the last 12 months have you personally experienced discrimination at work

12% 10% 39% 29%

KF24 - % of staff that would recommend this trust as a place to work or receive treatment

3.71 3.69 3.96 0.27

* Unusually, for KF18, the values for the 'White' and 'BME' groups are both higher than the Trust values. 13 of the 409 respondents appear not to have declared their ethnicity.

6. CQC intelligent monitoring (trust wide not location specific)

In the latest Intelligent Monitoring report (May 2015), this trust had three risks and no elevated risks.

The priority banding for inspection for this trust was six (the lowest priority band), and their percentage risk score was 1.58%.

The risks identified were as follows:

- Composite indicator: In-hospital mortality – Neurological conditions
- Composite of knee related PROMS indicators
- SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

End of life care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	**Good**

Information about the service

The end of life care service provided at Christchurch hospital includes 16 funded inpatient beds and a specialist palliative care day centre at the Macmillan unit. A community specialist palliative care service is also in place.

Admission to the Macmillan unit is offered to patients with advanced, progressive, incurable illness. These patients also have complex physical, psychological, psychosocial or spiritual needs, requiring specialist intervention. This is an NHS service supported by a local charity Macmillan Caring Locally. The Macmillan unit is multidisciplinary with specialist doctors, nursing staff, physiotherapists, and occupational therapists. A family support team and a benefits officer are also available. Staff at the unit also provides a palliative education programme to both community and hospital health care professionals.

The team of palliative care specialist nurses provide end of life care in the community and are based at the unit at Christchurch Hospital. The community nurse team deliver community support for the residents of Bournemouth and East Dorset seven days a week. They offer both outpatient appointments and domiciliary visits.

Between January 2014 and December 2014, there were 293 deaths at the Macmillan unit based at Christchurch Hospital

Before our inspection, we reviewed information from and about the hospital. During our visit, we spoke with five inpatients and one relative, 11 patients in the day centre and attended a visit to one patient in the community. We spoke with three consultants, two healthcare assistants in the inpatient ward and one in the day centre, three administrative staff, five staff nurses in the inpatient ward, lead sister in the inpatient ward, the community team lead sister, and the day centre sister. We also spoke with the senior clinical leader for the Macmillan unit, head of nursing and quality, housekeeping supervisor, chaplaincy, a member of the family support team, and four volunteers. We looked at six care records and 11 do not attempt cardiopulmonary resuscitation forms.

End of life care

Summary of findings

We rated end of life care as 'good' for safe, effective, and responsive, caring and well-led care.

People were protected from avoidable harm and abuse. There were reliable systems and processes in place to ensure the delivery of safe care. Nursing and medical staffing levels supported safe care and treatment. There were appropriate arrangements for out of hours cover.

Following the withdrawal of the Liverpool Care Pathway, the trust had introduced new personalised end of life care plans. This care plan, entitled 'personalised care plan for the last days of life', had been piloted at the Royal Bournemouth Hospital and, since August 2015, was in use at the Macmillan unit.

There was good multidisciplinary working, staff were appropriately qualified, and had good access to a comprehensive training programme dedicated to end of life care.

We observed a person-centred culture. Staff involved patients in their care and treated people with compassion, kindness, dignity, and respect. Feedback from patients and their families was consistently positive.

People's needs were mostly met through the way end of life care was organised and delivered. The rapid discharge service for discharge to a preferred place of care was responsive to the needs of patients and their families. The trust board were aware of an issue with delayed discharges. Delayed discharges affected timely admissions for all appropriate patients. There had been recognition of an increasing number of referrals to the specialist palliative care community team and action taken. The trust proposes in 2017-2018 to replace the existing specialist palliative care unit with a new expanded facility supported by Macmillan Caring Locally.

There was no end of life care strategy in place at the time of our inspection. During our inspection, the trust created an overarching strategy for end of life care with the aim of achieving full compliance with national guidelines. The medical director represented end of life care at board level. The associate medical director championed and supported end of life care. There was an end of life steering group that met monthly to monitor performance against national standards.

The specialist palliative care service based at the Macmillan unit was well led and worked in an integrated way across teams and services, with a governance structure and speciality risk register in place. The Macmillan unit and community specialist palliative care team mutually respected each other, and encouraged staff and public involvement. Colleagues at the Royal Bournemouth Hospital, also valued the support and advice provided by staff from the unit.

The palliative medicine consultants and community specialist palliative care service were working to continually improve the quality of end of life care across the trust.

End of life care

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

We rated safe as 'good'.

- Staff were aware of their responsibilities to report incidents and they received feedback on these incidents. Learning from incidents had taken place.
- There were clearly defined and embedded systems to keep people safe. Arrangements to minimise risks to patients included measures to prevent falls, and pressure ulcers. Staff demonstrated a good understanding of the early identification of a deteriorating patient. Safety briefings were a part of the ward routine.
- Procedures for infection prevention and control practice, the management of medicines and maintaining patient records were appropriately followed.
- Safeguarding vulnerable adults was given sufficient priority and staff took a proactive approach to the early identification of safeguarding concerns.
- Nursing and medical staffing levels supported safe care and treatment. There were appropriate arrangements for out of hours cover.
- Mandatory training for staff in the Macmillan unit inpatient beds was slightly below target, for the community specialist palliative care team it was significantly below target. Staff were aware of the need to book and complete their mandatory training.

Incidents

- In April 2015, the trust introduced an electronic incident reporting system. All staff we spoke with were aware of the process for reporting incidents, near misses, and accidents using the trust's electronic reporting system.
- Historically some nurses had not reported incidents using the electronic system, but had reported these verbally or by letter. These staff were aware they need to use the electronic reporting system.
- Between August 2014 and July 2015 there had been three serious incidents and one moderate. All serious incidents were investigated using root cause analysis. Two serious incidents related to deterioration in pressure areas to grade three pressure ulcers. Learning and actions included the introduction of a safety briefing, the purchase of new pressure relieving equipment and a 'care board' to alert staff when re-positioning of a patient was needed.
- The Macmillan inpatient unit reported 69 no harm or minor harm during the months April and May 2015. 27 of these incidents related to pressure damage. Reviews of the 15 incidents related to pressure damage that had occurred in the Macmillan unit, demonstrated appropriate action taken. The other 12 incidents relating to pressure damage occurred before admission to the Macmillan unit.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. The trust monitored duty of candour through their online incident reporting system. Discussion with staff demonstrated a good understanding of their responsibilities with regard to the duty of candour.

Safety thermometer

- The Macmillan unit monitored the incidence of pressure ulcers, falls with harm, catheter associated urinary tract infections (CUTI) and venous thromboembolism (VTE), using the NHS safety thermometer. The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. This enables teams to measure, assess, learn, and improve the safety of the care they provide.
- Safety thermometer data for the period March 2015 to September 2015 showed new harm in five out of six months. Where harm had occurred this was due to a new pressure ulcer and new urinary tract infection associated with a catheter. Actions needed to prevent pressure damage would be discussed with a patient. However, if a patient with capacity was not agreeable to being in a particular position in bed, this position was not used to relieve a pressure point. If a patient without capacity became distressed in a certain position, the most appropriate actions would be discussed with the family. The Macmillan unit sought advice as needed from the tissue viability specialist nurse.

- Safety thermometer information was not on public display when we visited. This meant patients and the public could not see how the unit was performing in relation to patient safety. The Sister told us they would consider moving this information to a public area.

Cleanliness, infection control and hygiene

- The Macmillan unit was visibly clean. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons.
- A Patient Led Environment Assessment of the Care Environment (PLACE) undertaken in February 2015, rated the cleanliness of the Macmillan unit as good, and did not recommend any improvements. The PLACE team is patient led, and consists of patient representatives and staff from the trust.
- Throughout the unit, we observed all staff complying with best practice and infection prevention and control policies. We observed staff wash their hands or use hand-sanitising gel between attending to patients. All staff observed were adhering to the dress code, which was to be 'bare below elbows'. Hand hygiene audit results for the period May 2015 to October 2015, ranged from 90% to 100% compliance. For September 2015 and October 2015 on the Macmillan unit, compliance had been at 100%.
- The viewing room in the mortuary was in need of cleaning when we inspected, the housekeeping staff immediately responded to this.
- A cleaning schedule was in place, and a checklist was being completed.
- There were procedures implemented for the management, storage, and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection.

Environment and equipment

- The Macmillan unit used syringe pumps for end of life patients who required a continuous infusion to control their pain. Syringe driver equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication, because the syringe drivers used were tamperproof and had the recommended alarm features. This followed the National Patient Safety Alert entitled Safer Ambulatory Syringe Drivers issued 16 December 2010.
- The Macmillan unit had been short of pressure relieving mattresses. However, eight were purchased in December 2014 and a further eight in January 2015, this enabled one for every bed.
- The PLACE audit undertaken in February 2015, described the internal environment as satisfactory in relation to tidiness and decoration. Some areas were described as a 'qualified pass' as awaiting decoration.
- Records demonstrated that equipment was regularly maintained and serviced.

- The end of life group had noted May 2015, that the viewing room in the mortuary was safe and functional, but in need of modernisation if it continued to operate.
- The mortuary had a refrigeration system that was regularly serviced. The alarm was not located in the switchboard as stated in the trust policy where monitoring would be possible 24 hours a day seven days a week. There was an external visible and audible warning light in place, outside of the mortuary. The trust told us the housekeepers monitored this, but no records are kept.

Medicines

- Medicines were stored and managed safely at the Macmillan unit, and fridge temperature monitored and recorded regularly. A pharmacist with a registered nurse undertook a check of the management of controlled medication on the Macmillan unit in July 2015, with no compliance issues identified. Emergency medicines were available, and we these were regularly checked. An audit in August 2015 did show gaps in documentation that daily checks had taken place, which the sister had addressed, and checks were satisfactory at the time of our visit.
- The trust had standard operating procedures for the prescribing of anticipatory medicines, medicines prescribed for the key symptoms in the dying phase (pain, agitation, excessive respiratory secretions, nausea, vomiting, and breathlessness).
- We reviewed six medical and nursing case notes of those patients identified as being in the last hours or days of life. Anticipatory medications had been appropriate prescribed.

- Several oxygen cylinders were stored in a corridor in mobile stands. The ward sister was aware of the need to review the storage of the oxygen cylinders.

Records

- Individualised nursing care plans and a 'personalised care plan for the last days of life' (PCPLDL) were used. The nursing section of this was kept with the patient, the medical section in the medical notes. This enabled nursing information to be available at the bedside, to the multidisciplinary team, patients', and their relatives.
- An electronic patient record was used for community patients. Community specialist palliative care staff from the Macmillan unit could not access the electronic patient record when on home visits. They took paper notes, for documenting care and treatment, and on return updated the patient electronic record. The community nurses expressed concerns at the delay and risk they might get interrupted before updating a patient's electronic record. At the time of our visit there had not been are incidences, when a patient's electronic record had not been updated.
- We reviewed the medical and nursing notes for six patients who were receiving end of life care. Notes were accurate, complete, and up to date and all except one was legible. One member of nursing staff handwriting highlighted as illegible at the time of our visit. This concern was escalated at the time of our visit to the nurse in charge.
- Medical notes for end of life patients were stored in trolleys inside the nurses and/ or doctor's office. Staff were not always present in these offices. The doors of these offices were not locked. The notes trolleys were not locked. This level of security would not have prevented unauthorised access.

Safeguarding

- There was a trust wide policy, which outlined the processes for safeguarding children and vulnerable adults.
- Information received following our inspection showed the overall uptake of adult safeguarding training at the Macmillan unit to be at 84% against a trust target of 90%, and for the Macmillan community team 66%.
- Nursing staff we spoke with had an awareness of how to protect patients from abuse. Staff were knowledgeable about safeguarding and the process to refer safeguarding concerns. One member of staff we spoke with could recall a recent safeguarding incident regarding an end of life care patient. This was in relation to financial concerns, and a safeguarding alert appropriately raised.

Mandatory training.

- Mandatory training included tissue viability, medicines management, basic life support, manual handling, falls prevention, safeguarding, and fire safety. The Macmillan unit compliance with mandatory training was at 82%, against a target of 90%. Compliance for the community team was at 59%. The clinical team lead had discussed the need to improve compliance with her team, at a recent palliative care sisters meeting.
- During our inspection, the community team had been experiencing a high level of referrals. Staff feedback that his may have been a factor in the level of mandatory training compliance. The concern with their workload was being addressed by the unit and staff had been made aware of the need to book and attend for mandatory training.

Assessing and responding to patient risk

- We reviewed the nursing notes of six patients on the Macmillan unit. Risks to patients, for example pressure damage, were assessed, monitored, and managed on a day-to-day basis using nationally recognised risk assessment tools. Risk assessments for patients were completed appropriately on admission and reviewed at the required frequency to minimise risk.
- The PCPLDL provided nursing and medical staff with prompts to ensure, symptoms and risks, were managed without delay.
- Safety briefings were in place three times a day at nursing staff shift handovers. These provided the opportunity for staff to share information on staffing, patient allocation, bed availability, patients at increased risk of falling, patients with pressure damage. Records demonstrated that safety briefings occurred regularly and information was appropriately shared.

Nursing staffing

- Nursing numbers were assessed using a pre-determined template, based on national guidance. The safe staffing

End of life care

levels were displayed at the entrance of the ward, including planned and actual numbers. The Macmillan unit also provided a 24 hour advice line for staff, patients and relatives

- The matron advised nurse staffing was reviewed twice yearly, and the last review had taken place in March 2015. It had been recognised at the last review that an increase from one to two band six whole time equivalents was required. This positon had been recruited to.
- We reviewed the nursing rota for a six week period during September and October and found that planned staffing levels were met for the majority of shifts. The rota we reviewed over the last six weeks demonstrated a minimum of one trained nurse to eight patients at all times, which meets national guidance. On the morning shift and evening shift there was one trained nurse to six patients. There was one whole time equivalent (wte) band five and one wte band two vacancies. The ward sister advised over the last six weeks there had only been one shift which had been difficult to staff, and there had been a diluted skill mix with an increased number of healthcare assistants. To replace registered nurses the Macmillan unit would try to contact bank staff, who were familiar with end of life care.
- If a patient required one to one support, an additional member of staff would be requested and provided, to support a patient at high risk of a fall. Patients told us the staff and the ward was busy but the nursing staff looked after them and they did not have to wait long for help or care.
- Nursing staffing for the Macmillan community team staffed with a team leader at band eight. The team consisted of 4.6 wte band seven nurses, four wte band six nurses with one vacancy at present, one band six wte development post and a 0.4 band five wte equivalent triage post. Following the submission of a business case in August 2015 due to increasing number of referrals, three further band six wte were due to commence in January 2016.
- Handovers took place three times a day at staff shift changes in the Macmillan unit. A call log was also in place for any out of hours calls, so the details could be handed over to the relevant member of specialist palliative care staff.

Medical staffing

- Two palliative medicine consultants supported by specialty doctor(s), up to two specialty registrars and one junior doctor provided day to day medical cover at the Macmillan unit. The number of palliative medicine consultants within the trust and for Christchurch hospital was only slightly below national recommendations for 1.6 to 2 wte palliative care consultants per 250,000 population. The Macmillan unit palliative medicine consultant felt the medical staffing to be appropriate.
- Medical support out of hours was provided by a team, including palliative medicine consultants and specialty doctors, organised using an on call rota.

Major incident awareness and training

- The service had a major incident policy in place for all trust staff and outlined how to respond in the event of an emergency (major incident). Major incident training was included on the trust corporate Induction and in the local induction for all new staff.
- The mortuary service had a policy about how to respond in the event of a major disaster that included managing increased capacity. Also, how the mortuary would operate following any incident that interrupted the day-to-day running of the mortuary.

Are end of life care services effective?

By effective, we mean that people’s care, treatment, and support achieved good outcomes, promoted a good quality of life, and was based on the best available evidence.

We rated effective as “good”.

- People’s care and treatment was planned and delivered in line with current evidence based practice. In response to the 2013 review which promoted the withdrawal of the Liverpool Care Pathway (LCP), the trust had developed ‘the personalised care plan for the last days of life’ (PCPLDL). The PCPLDL was introduced into the

Macmillan unit in August 2015. This followed the introduction of the PCPLDL at The Royal Bournemouth Hospital followed by an audit, indicating some minor amendments required.

- Patients had appropriate access to pain relief. Anticipatory end of life care medicines appropriately prescribed for symptom control and patients were provided with pain management support, although the effectiveness not always well documented.
- There were examples of co-ordinated care through effective multidisciplinary team working to centre care on the patient. Continuity of care with GPs and in the community was assured, by a telephone call to a GP when required. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Medical and nursing staff had received specialist training. There was a need to source clinical supervision for staff, and improve appraisal compliance.
- Patients had access to seven-day services.
- Ten of the eleven 'do not attempt cardiopulmonary resuscitation (DNACPR) forms' reviewed were appropriately completed.

Evidence-based care and treatment

- At the time of our inspection, the service created a five page document that was an overarching strategy. This was based on national guidance, the National Institute for Health and Care Excellence (NICE) quality standard 13, which defines clinical best practice in end of life care for adults, and the Department of Health's National End of Life Care Strategy.
- A **'**personalised care plan for the last days of life' (PCPLDL) was in use for patients in the last 72 hours of life. This document guided delivery of the priorities of care for patients recognised to be in their last few days or hours of life, for whom no potential reversibility was possible or appropriate. This document had been in use in the Macmillan unit since August 2015. The hospital palliative care team at the Royal Bournemouth Hospital had undertaken an audit involving 71 patients and the use of the PCPLDL. This demonstrated some further education was needed for doctors and nurses. That had been planned, along with a further audit for September 2015. The development of the document was in response to the 2013 review of the Liverpool Care Pathway.
- The Macmillan unit submitted data for the National End of Life Care Audit – Dying in Hospital regarding key performance indicators, just prior to our inspection. The audit results will not be available until February/March 2016. The Macmillan unit did not participate in the previous National Care of the Dying audit that was last conducted two years ago.
- Two audits had been undertaken in the Macmillan unit and are detailed in patient outcomes below.
- A review of six medical and nursing records showed symptom control for end of life patients managed effectively, and in accordance with the NICE Quality Standard CG140 Opioids in Palliative Care. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care of adults. Following an opioid audit of 16 patients, one area of compliance was identified that needed to be addressed, and that was the prescription of a laxative with strong opioids. The specialty doctor in palliative medicine had designed a written leaflet for patients that includes frequently asked questions such as, 'what are opioids?' What are the side effects of opioids?

Pain relief

- Anticipatory prescribing for patients was managed well. The patient records we inspected showed patients received appropriate pain relief. Patient records provided instructions for staff on action to take to meet patient's individual needs.
- All staff we observed were pro-active in managing patient's pain. Where patients had required pain relief at times other than their regular dose, we saw this given appropriately.
- During our inspection , we saw gaps in the pain assessment tool documentation to monitor the effectiveness of pain relief. The ward sister was aware of this issue and was working on a plan to improve this aspect of documentation with the Macmillan unit team. The sister was beginning to notice an improvement in the documentation of the monitoring of the effect of pain relief.
- The Macmillan unit used syringe pumps for end of life patients who required a continuous infusion of pain relief medication to control their pain. The ward sister had introduced a 'care board' that included a reminder to check if a patient required analgesia before movement. The sister commented on the good use of the care board by members of the team.

Nutrition and hydration

- An audit undertaken by the Patient Led Assessment of the Care Environment (PLACE) team in February 2015, found the food well-presented and prepared for a patient, for example, chicken taken off the bone.
- There were protected meal times to support patients with meals and drinks and water was readily available.
- Many of the patients admitted to the Macmillan unit had undergone nutritional screening pre admission to check for risks of malnutrition. On admission to the Macmillan unit, a patient's nutritional screening was not undertaken using a nationally recognised assessment tool. The ward sister was planning to implement the use of the Malnutrition Universal Screening Tool (MUST) on the unit. The sister had requested bed scales, to assist with the weighing of a patient.
- Patients who required a dietitian referral were identified by medical and nursing staff. The dietitians were contacted by telephone for advice regarding a nutritional plan for a patient. Information was also available on the intranet site. Community palliative care patients referred to the community nutrition team for advice and support.
- Medical staff were prompted via the PCPLDL document to consider the appropriateness of different options for supporting nutrition and hydration in end of life care.

Patient outcomes

- The Macmillan unit was contributing data about palliative and end of life care to the National Minimum Data Set (MDS). The National Council collects the MDS for Specialist Palliative Care Services for Palliative Care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity on a continuing basis. It is the only annual data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales, and Northern Ireland.
- The Macmillan unit participated in a service evaluation undertaken in August/September 2014 of 38 specialist palliative care services in England, by the association for Palliative Medicine of Great Britain and Ireland. This included 16 hospice in patient units, 10 home care teams, and twelve hospital support teams. Overall the median percentage of dissatisfied or very dissatisfied responses was mid-range at 4.5% (range 1.5 – 6.5%). The qualitative data for the Macmillan service at Christchurch hospital, was overwhelmingly positive. There were two negative comments, one regarding the Macmillan inpatient unit and one regarding the community team, suggesting communication could have been more sensitive. With regard to the community comment, there seemed to an issue with expectations of what the community care service can provide. The relative was distressed and had a difficult experience. The trust believe that the appointment of three new community specialist palliative care nursing posts will help with the increasing demands on the service. The results of the survey have been shared with the community specialist palliative care nurses. The comment with regard to the Macmillan inpatient unit was about the way a patient was included in care and treatment decisions. This has been shared with the ward sister.
- An inpatient survey undertaken by the specialist palliative care team in 2014 highlighted a great deal of satisfaction with the quality of care in the Macmillan unit. The survey found that 46 out of 50 patients surveyed felt they had enough time to explore their feelings and emotions. Three people felt this was not applicable to them, and one felt this had not been the case.

Competent staff

- A local induction checklist was available for temporary staff, and we saw evidence that this was in use.
- The appraisal rate for the nursing staff on the unit was 75% in February 2015 but had dropped below this level, following the introduction of a new appraisal format. We were shown the plan the unit had in place to bring the appraisal rate to the target of 90%. Following our inspection we were advised compliance for the community specialist palliative care nurses was 55%.
- Training had been delivered to the Macmillan unit staff in the use the new model of syringe drivers in the summer of 2015. At the time of our visit there was no policy in place supporting the new model of syringe drivers. The supporting policy was due for publishing on the hospital intranet on 2 November 2015. The delay was due to the changeover of the syringe drivers at The Royal Bournemouth Hospital not planned to take place until 2 November 2015. On our unannounced inspection on 4 November 2015, the syringe driver policy for the new syringe driver pumps was on the hospital intranet.

- The Macmillan inpatient team had monthly in house training. An update session for staff in the Macmillan unit who have to give advice to community patients, out of hours was also planned. This was to ensure quality and consistency of advice and support.
- An accredited advanced communication skills course ran six times this year for consultants, this was attended by 58 delegates and received excellent feedback.
- The palliative medicine consultants run a 'Do Not Attempt Cardiopulmonary Resuscitation Course' (DNACPR) and an 'Allow a Natural Death' (AND) course three times per year for consultants to attend. This course also received very positive feedback. The palliative medicine consultant we spoke with at the Macmillan unit was enthused about the value of these courses to support effective end of life care.
- Three advance care-planning days were provided this year for senior practitioners and GP's.
- In the Macmillan community specialist palliative care team the band eight and four band seven nurses were non- medical prescribers, minimising delays with managing a patient's symptoms. Community team have also undertaken an 'Allow Natural Death Decision Making course', enabling a prompt response to a patient's deteriorating condition. Band six nurses in the Macmillan community specialist palliative care team undertook a health assessment and physical examination university course.
- In the Macmillan unit, staff were unable to access clinical supervision. The ward sister had noted in the July 2015 ward meeting that the matron was in the process of sourcing clinical supervision for staff.
- A Palliative Care in Advance Chronic Conditions Conference (Non-Malignant Diseases) was planned for 2016. A motor neurone disease conference held in January 2015 has been organised for any member of staff to attend in January 2016.

Multidisciplinary working

- The Macmillan inpatient unit had strong links with the Macmillan community team also based at Christchurch hospital. This facilitated effective multidisciplinary working. A weekly multidisciplinary team (MDT) meeting was held in the Macmillan unit. In regular attendance were the three palliative medicine consultants, specialist registrars, community palliative care sisters, hospital palliative care specialist nurse, therapy, clergy, ward nurse, discharge co-ordinator, amongst other members of the multidisciplinary team. Staff we spoke with found this meeting to be very valuable, in coordinating effective patient care.
- At the MDT discussions took place regarding all new referrals, to community palliative care team, hospital palliative care team, and Macmillan inpatient unit. The aim of the discussion and communication to review the effectiveness of care
- The specialist palliative care team and a consultant neurologist held a joint quarterly clinic for review, and follow up of patients with motor neurone disease.
- There was also a quarterly motor neurone disease multidisciplinary meeting, in which patients with motor neurone disease, under the care of the specialist palliative service were discussed. Those attending this meeting were inpatient therapy, community therapy, wheelchair services, speech and language therapy, a doctor and a nurse.

Seven-day services

- Specialist palliative care telephone advice was available to patients, carers and staff 24 hours a day, seven days a week from the Macmillan unit. An appropriately trained member of nursing staff was located at the Macmillan unit for advice. Where appropriate calls were discussed with the on-call senior palliative medicine physician. A log of advice calls was kept so that it was available for the relevant specialist palliative care sister the following day.
- Each letter from any part of the specialist palliative care service and notified the GP and referring clinician to the availability of the 24-hour advice line and contact number. The availability of telephone advice was also advertised in the palliative care handbook and the trust intranet.
- The community specialist palliative care sisters were available for advice and patient assessment (including visiting patients at home or in a residential on nursing), seven days a week, between the hours of 8am to 6pm.
- The mortuary at Christchurch Hospital was available 24 hours seven days a week.
- Chaplaincy support was available seven days a week.
- Pharmacy was available on site Monday to Friday, and there was a pharmacist on-call for advice and any supply issues outside of normal working hours.

End of life care

Access to information

- Record keeping in the Macmillan inpatient unit was paper based. The Macmillan community specialist palliative care team, as part of the specialist palliative care service completed an electronic patient record, and actions from the multi-disciplinary team meetings recorded in the electronic patient record. The records included advance care planning and allow a natural death forms. At Bournemouth General Hospital and Poole General hospital, viewing of electronic patient records was possible.
- The Department of Health wants all hospital trusts to be paperless by 2018. As a result, the Royal Bournemouth and Christchurch Hospitals, Poole Hospital and Dorset HealthCare University NHS Foundation Trusts are working together with this project to make notes electronic, and eventually replace paper-based notes.
- GPs were not able to access this record at this stage of the records project, so on discharge from the Macmillan unit the GP informed by telephone and a detailed paper discharge summary including diagnosis, support needed by the patient and a full medication list.
- When we accompanied a community specialist palliative care nurse to visit a patient, she had some notes with her, and updated some paper records in the house. Although the community specialist palliative care sisters were due to be provided with IPADS, these were not used in the community, due to connectivity problems. These will be rolled out to all sisters once the connectivity is working fully. When the community specialist palliative care nurse returned to the Macmillan unit, they updated the patient's electronic record. During the transition phase from paper to electronic patient records, the current system although causing duplication of record keeping, was enabling access to information for all involved in a patient's care.
- Medical staff that we spoke with did not raise any concerns with the availability of timely test results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff on the Macmillan unit were aware of what actions to take to ensure Mental Capacity Act 2005 guidance followed when patients did not have capacity to consent to care and treatment. For example, staff had made two applications for patients to request Deprivations of Liberty Safeguards during August 2015.
- We reviewed 11 DNACPR forms during inspection, six in the Macmillan unit and five in the Macmillan day centre. All forms showed evidence that a discussion had taken place with the patient and or their relatives before the form had been signed by medical staff. On one form in the day centre, it was not clear as regards the assessment of a patient's capacity.

Are end of life care services caring?

Good

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

We rated caring as 'Good'

- We observed a person-centred and caring culture. Staff involved and treated people with compassion, kindness, dignity, and respect. Feedback from patients and their families was consistently positive.
- Staff valued and respected the totality of both, patients' needs and the needs of their families. Patients' emotional, social, and religious needs were taken into account and reflected in how their care was delivered. Staff listened to a patient's concerns, involved them in their care and agreed a plan of their ongoing care and treatment.
- All staff demonstrated a commitment to providing compassionate care not only to patients but also to their families and post bereavement. Patients and their families were respected and valued as individuals and were empowered as partners in their care.

Compassionate care

- We spoke with four patients in the Macmillan unit, 11 patients in the day centre and a relative. All were also highly complimentary about the staff, for example, "they could not take care of you better". One patient told us his symptoms were well managed, and that he would now be able to go home again. The patient gave an

example of a concern that he had, following a cancelled home visit by the cardiac nurse. This concern was addressed within half an hour, to the patient's satisfaction.

- During our inspection, we observed staff were compassionate, caring, and treated patients with dignity and respect. All the staff we spoke to were very clear about their role in ensuring people received appropriate support, to promote their well-being. For example, we heard of examples where staff made extra efforts to make Christmas a happy event.

Understanding and involvement of patients and those close to them

- Patients we saw told us they were involved in their care and treatment. They knew the plans for their care, for example, "I'm expecting to have a blood transfusion later, and then hope to go home".
- The patients we spoke to very much appreciated how the consultant came round on her own and sat and talked with them. They went on to say it can be very daunting when four or five junior doctors come round with the consultant.
- A patient who we visited in the community was involved in his care at all times during the visit. On leaving, the community specialist palliative care nurse left with a plan in place that they would telephone over the weekend to review his condition. The community specialist palliative care nurse advised the patient to ring sooner if he had problems prior to their telephone call.
- All staff were to be provided with communication training, based on the 'Sage and Thyme' model. The 'Sage and Thyme' model provides evidence based communication skills training to all levels of staff. The model gave a structured and quick approach for dealing with the concerns of patients and their family.
- Benefits advice in relation to financial coping was available from a benefits advisor based in the Macmillan unit, helping to reduce stress for patients and their relatives

Emotional support

- Chaplains and nurses provided emotional support to patients and relatives who were experiencing difficulties in coming to terms with death and dying.
- A nurse would always attend to provide emotional support if a relative needed an opportunity to view their loved one in the mortuary viewing room.
- The family support team provided support away from the Macmillan unit by way of a monthly group for carers and relatives recently bereaved. The family support team had the skills to provide emotional support, information, and counselling to patients, relatives, and carers.
- The service had developed a volunteer task description, an in-depth training package, a volunteer handbook, and distinct guidelines for ward volunteers and drivers. An example of the training included 'how to be with a patient and the role of empathy and compassion' and 'how to deal with difficult questions'. By June 2015, seven volunteers had been trained to be bedside companions. A family sent a card, following the support of a bedside companion, which included the following words inside "You were amazing and I don't know how we would have coped without you. You certainly made it feel a bit less scary".
- A memorial service takes place every two months at the Chapel at Christchurch Hospital. The attendance varied between 30 – 60 people. After these services, tea and coffee are provided, providing an opportunity for relatives to feedback.

Are end of life care services responsive?

Good

By responsive, we mean that services were organised so that they met people's needs.

We rated responsive as "good".

- The service was planned and delivered in a way, that took account of the importance of flexibility, choice and continuity of care.
- People's needs were mostly met through the way end of life care was organised and delivered. The rapid discharge service for discharge to a preferred place of care was responsive to the needs of patients and their families.
- There had been recognition of an increasing number of referrals to the specialist palliative care community

team and action taken. The trust was planning to replace the existing specialist palliative care unit with a new expanded facility support by Macmillan Caring Locally in 2017/18.
- The needs of different people were taken into account in the planning and delivery of the service. A family support team, consisting of a social worker and a psychologist was available, and a benefits advice officer. The volunteers on the Macmillan unit, played an important role, in complementing the work of the staff
- The Macmillan unit had received no formal complaints in the last 12 months. In May and June 2015, the unit had received commendations.

However,

There was an issue with delayed discharges and this delayed timely admissions for all appropriate patients. The trust board were aware of this.

Service planning and delivery to meet the needs of local people

- There were designated beds for patients receiving palliative care. The Macmillan unit had 20 bed spaces, but was funded for 16 inpatients. This included five single rooms, one of these with ensuite facilities In addition to this a community specialist palliative care team and the Macmillan day centre. The trust proposes to replace the existing specialist palliative care unit with a new expanded facility in 2017/2018, with support from Macmillan Caring Locally.
- Referrals to the specialist palliative community service overall rose by 38% during the period 2012/13 to 2014/15. Recruitment had been agreed for three band six whole time equivalents to commence in January 2016. This will provide three teams within community specialist palliative care, covering three defined geographical areas.
- Facilities were available for relatives to stay close to their loved one. Relatives offered the use of a visitor room or were able to stay in the room with their relative. Friends and relatives were able to use a small refreshment snack bar in a spacious lounge/ day room.
- The unit was flexible, providing choice and continuity of care. The day centre was in the same building as the Macmillan inpatient unit and community specialist palliative care team, allowing an integrated service and regular review of patients attending the day centre. The purpose of the day centre was to provide an inclusive programme for patients with identified specialist palliative care needs within a day unit setting, incorporating medical assessment, psychological support, and allied health provision. The patients we spoke with all said what a positive difference the day centre had made to their lives at this difficult time. The trust had undertaken chaplaincy review following the publication by NHS England of NHS Chaplaincy Guidelines in March 2015. Chaplaincy staffing was under review to ensure best practice in supporting the diversity of religions, beliefs, and cultures within the population that are growing.
- Between April 2014 and March 2015, there were 468 admissions to the Macmillan unit. Since April 2015 of this year, 88% of those patients had a cancer diagnosis, the other 12% non-cancer.
- The type of non- cancer diagnosis were not identified. However, the community specialist palliative care nurses talked about their work involving people with motor neurone disease at the end of life.

Meeting people's individual needs

- The 'personalised care plan for the last days of life' (PCPLDL) documentation was commenced when the patient was recognised to be likely to be in their last 72 hours of life. Advance care planning and preferred place of death was included in this document.
- At the Macmillan unit day centre, the manager advised us that advance care planning discussed with patients, if the patient is ready to discuss.
- Information was available for patients and carers including, 'specialist palliative care nurse contact numbers and service details leaflet', there was a separate community and hospital version ; 'guide to the Macmillan unit for patients and visitors'; 'planning for your future care – a guide' and 'preferred priorities of care'. Other leaflets were available that were given to patients as appropriate.
- Age appropriate information to support children and teenagers when a member of the family was in the Macmillan unit was available through the Family Support Team
- Bereavement packs included written information for bereaved family and friends. Specific leaflets for children of the deceased were available at the Macmillan unit through The Family Support service.

- Interpreting services were available. Staffs demonstrated an awareness of the language needs of the local community and were aware of the process they would follow should they require an interpreter.
- The spiritual needs of patients were identified in the PCPLDL, ensuring appropriate support access as needed for a patient.
- A member of nursing staff from the Macmillan unit met with relatives to collect death certificates at a pre-arranged time. Staff commented that many relatives appreciated this opportunity for some discussion. If relatives felt they could not come back, staff would arrange for the certificate and property to be collected from the general office at The Royal Bournemouth Hospital, by relatives or carers.
- The garden area was a lovely area, which also included an aviary and a fishpond, for patients and their relatives. The volunteers were supportive in the up keeping of the garden area.

Access and flow

- Patients were admitted to the Macmillan Unit seven days a week, between 9am and 8pm. If a patient needed to admission between 8pm and 9am, patients were usually assessed in the emergency department or acute medical unit at the Royal Bournemouth Hospital. They may also be assessed at Poole General Hospital for oncology patients. If a patient admitted either at Poole or Bournemouth, they would be put under the care of an appropriate consultant (oncologist, physician, or surgeon). The patient was then assessed for transfer to the Macmillan unit the following day if appropriate, bed availability permitting.
- Bed occupancy for the period was 89.6% for the months May to September 2015. In acute trusts it is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients. From talking with staff delayed discharges were a cause of the high occupancy.
- There were 236 admissions to the Macmillan unit from 1 April 2015 until 30 September 2015. 61 of these patients were discharged home and 17 to a care home. The service was planning an audit to record the percent of patients dying in their preferred location during November/ December 2015.
- From March 2015 to August 2015, 22 patients had experienced a delayed discharge from the Macmillan unit. This was in the main due to delays with packages of care being available (eight patients) and nursing home having places available (11patients). The length of delay varied from three days to 26 days.
- The palliative medicine consultant we spoke with and the discharge co-ordinator particularly highlighted concerns with patients who were funded for continuing healthcare by either Dorset Clinical Commissioning Group (CCG) or Hampshire CCG. During the period March 2015 to August 2015 there had been two patients, one delayed by 25 days and the other 5 days. This concern, regarding level of funding for care in the community, was recorded on the end of life care action log, as escalated to the chief executive in October 2014. The discharge co-ordinator explained how she would use the generalist palliative care team when they had capacity, funded by Dorset Clinical Commissioning Group, until a package of care could commence.
- Nursing staff told us rapid discharge for those patients in the last days or hours of life could usually be arranged within 48 hours. The time effected by when personal care could be provided where needed, rather than the provision of equipment or when medication to take out ready.
- A community specialist palliative care sister we spoke with raised a case where it had taken seven to eight weeks to arrange a joint visit with a district nurse for a patient with motor neurone disease. Previously district nurses linked to GP surgeries now in hubs, and communications have been more challenging. It was expected that increase in staffing for community specialist palliative care team would improve access to the service. The clinical lead has suggested a mapping exercise is undertaken to explore how best to plans ways of working.
- An audit completed by the community specialist palliative care team, for the period 3 February 2014 to 9 May 2014, looked at the number of patients admitted within 24 hours of a request for admission. The audit found that when patients who were not appropriate for admission to the Macmillan unit (improvement in condition, patient choice or transfer to a more appropriate setting, for example, a nursing home) removed from the data, then the percentage admitted within 24 hours was 73%, with a further 19% admitted but not within 24 hours.
- The trust has designed an audit for ‘avoidable hospital admissions’ which will be for 50 patients, which is

currently with their audit department to produce the data collection form. The audit findings may enable actions, to reduce demand for inpatient beds at the Macmillan unit.

Learning from complaints and concerns

- During the last 12 months, the Macmillan unit had not received any complaints. In May and June 2015, the Macmillan unit received 179 commendations.
- The ward sister had recently organised for a red box to be placed at the entrance of the Macmillan unit inviting comments/ feedback from relatives and carers visiting the ward. This was to enable any concerns from relatives or carers to be known and addressed.

Are end of life care services well-led?

We rated well led as "good".

- The vision to develop the service to achieving full compliance with national guidelines was shared passionately by all staff in the service.
- The medical director represented end of life care at board level. From board meeting minutes, the end of life care service was not a regular agenda item, but discussed when issues arose.
- End of life care was championed and supported operationally by the associate medical director, who advised the medical director of issues that needed to be discussed at board level.
- There was an end of life steering group that met monthly to monitor performance against national standards.
- The specialist palliative care service based at the Macmillan unit had effective leadership and worked in an integrated way across teams and services, with a governance structure and speciality risk register in place. At their monthly governance meeting, the audit programme was discussed.
- The Macmillan unit and community specialist palliative care team mutually respected each other, and encouraged staff and public involvement. Colleagues at the Royal Bournemouth Hospital, also valued the support and advice provided by staff from the unit.
- The palliative medicine consultants and community specialist palliative care service were working to improve the quality of end of life care more widely.

However,

- There was no strategy in place at the time of our inspection. During our inspection the trust created an overarching strategy for end of life care based on achieving full compliance with national guidelines.
- Some staff from the community specialist palliative care team told us they had only recently met with senior managers from the trust. They felt that senior managers were not visible or aware of the needs of their service.

Vision and strategy for this service

- Staff had a passion and commitment to the provision of end of life care. The vision for the service was to provide high quality end of life care and palliative care across the Macmillan unit and the community specialist palliative care service. The team clearly understood the priorities for end of life care services.
- The five page strategy created at the time of our visit set out key operational and clinical developments, incorporated a timeline, to ensure the service evolved in line with the needs of patients. For example, it included educational priorities and developments such as the 'electronic palliative care coordination system'. The trust had not had the opportunity to share this document with staff.
- The trust had a well-established end of life steering group committee chaired by the associate medical director. The purpose of this group was to promote and drive the end of life care vision and strategy forwards, and advise the trust board on plans for end of life care. The medical director provided trust board representation.
- Monthly steering group meetings included representation from other services within the trust including a governor, therapy service, and medicine. A member of Dorset Clinical Commissioning group also attended. The action log from the meetings was used to monitor progress and demonstrated a strong focus on driving through development to meeting with national guidelines, for example, the development of the 'personalised care plan for the last days of life'. From the action log, we could see where items had been actioned and closed.

Governance, risk management and quality measurement

- The Macmillan held a clinical governance meeting monthly, which included on the agenda surveys undertaken, audits, guidelines and policies, education and any adverse incidents. An audit programme was not in place. The notes of the meeting detailed who was responsible for taking actions forward. During our inspection we fed back to the clinical lead that the policy, 'care of the deceased' policy had been due for review in 2013. The clinical lead was going to look into this concern further.
- The community specialist palliative care sisters held monthly meetings for sharing and discussing information, including discussions about education and improvements in communication across the community. For example, a discussion around whether doctors on the ward could use the electronic patient record to communicate decisions made on the ward rather than paper records. This meeting was a sharing information and discussion meeting, with no clear ongoing actions identified.
- A cancer risk register, recently updated, was in place. A risk assessment was completed if risks were identified. A risk assessment had recently been completed, and submitted to managers in the speciality, regarding the operation of a trolley in the mortuary that posed a risk to staff.
- Two internal peer reviews of the environment and quality of care on the Macmillan unit had been undertaken. An action log was in place, and actions signed off as completed. For example, some out of date information regarding safeguarding adults and children removed, and information updated.
- The sister on the Macmillan unit held a monthly ward meeting for all staff where information shared, which included operational issues, for example measures to ensure safe staffing.

Leadership of service

- A consultant in palliative medicine was clinical lead and proactively championed the end of life and palliative care service. Leadership within end of life care was strong, with clearly defined responsibilities for all staff responsible for delivering care.
- The sister on the Macmillan unit was focussed on driving improvement, for example, requesting a peer review of the unit. The sister also led by example, we observed her being very involved with the meal service.
- Staff from the community specialist palliative care team said that they had only met with senior managers recently, and were concerned regarding their understanding of the specialist nature of the role. From the minutes of the Board meeting, the value of the end of life care service was recognised. The message of board support had not reached the community specialist palliative care team. All the staff we spoke with felt their line managers were visible, approachable, and supportive. They were aware of the service lead for end of life care and reported good access to the lead and, the community specialist palliative care team, the family support team and benefits officer.

Culture within the service

- We saw effective team working at the unit and an obvious mutual respect amongst staff. All the staff we spoke with told us they felt proud of working for the trust and enjoyed working within end of life care. We observed staff working well together and could see staff were supportive of each other.
- Staff were clearly committed to providing good end of life care at the Macmillan unit. To complement the Macmillan unit team, at June 2015 there were about 116 'active' volunteers. The volunteers contributed to the positive culture in the Macmillan unit.
- Student nurses from their second year onwards were welcomed to the unit, and supported with an information pack about the service. A staff member we spoke to explained she was the lead for student support on the ward, and aware of the need for sensitive exploration of a student nurse's background, to ensure at that time they would be able to benefit from working in the Macmillan unit.
- There was a culture of openness and transparency. The sister held a meeting with the healthcare assistants. At the meeting, they requested a reminder for the team about ensuring secure management of a patient's property.

Public engagement

- There were plans to consult relatives and friends on the end of life care strategy.

- There were no members of public or relatives on the end of life steering group.
- The specialist palliative care services participated in a service evaluation, sent to relatives, by the association of palliative medicine for Great Britain and Ireland.

Staff engagement

- The community specialist palliative care team line manager listened to concerns from staff. Following a team meeting, the community specialist palliative care sisters wrote a letter to their line manager about their caseload. The line manager then completed a risk assessment and a business case, with the outcome of agreement to recruit additional staff.
- The sister in the Macmillan unit along with a general ward meeting held meetings with the health care assistants. This facilitated detailed discussions around a patient's care, such as continence management and use of continence aids, to ensure best ward practice to prevent damage to a patient's skin.
- The volunteering project lead had planned and implemented long service recognition awards for volunteers. The volunteers had all received training for various tasks, and when we visited were actively engaged and cheerful in supporting patients with drinks.

Innovation, improvement and sustainability

- A palliative medicine consultant from the Macmillan unit attended the trust morbidity and mortality meetings. The consultant found their contribution to be valued, and that it enhanced others knowledge of end of life care issues for individual patients. Specialist palliative medicine consultants attended gastroenterology, surgical, respiratory, stroke, and acute medicine mortality and morbidity meetings. There was a proposal for them to join urology and medicine for older people mortality and morbidity meetings.
- There were plans to roll out the electronic palliative care co-ordinating system (EPaCCS) which would help measure the effectiveness of palliative care services.
- The Macmillan unit community palliative care sisters were involved in the Dorset wide motor neurone disease group.
- The trust did have performance measures for end of life care on a dashboard, but the Macmillan unit performance was not included in this data.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	**Good**

Information about the service

Christchurch Hospital is part of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and provides outpatient and diagnostic imaging services for a wide range of medical and surgical clinics including rheumatology, geriatric medicine, gastroenterology and dermatology. There is day hospital service providing assessment, treatment and rehabilitation for older people five days a week. There were 9254 attendances in the period January-December 2015The Royal Bournemouth and Christchurch NHS Trust provides cardiology, gastroenterology, respiratory medicine, endocrinology, haematology, oncology and stroke services within the medical services. The trust also provides services to elderly patients and those living with dementia. There is a 52 bedded Acute Medical Unit (AMU), and a Treatment Investigation Unit (TIU). All these services are provided from the Royal Bournemouth Hospital. A day hospital service providing assessment, treatment and rehabilitation for older people is located in Christchurch Hospital..

At Christchurch Hospital the outpatient appointments are available from 8am to 5pm, Monday to Friday. The diagnostic imaging department is open for appointments from 8am to 4pm and offers plain film radiography and ultrasound. Phlebotomy services are also available, with the clinic open 9am to 3.30pm Monday to Friday. In the period June 2014 to July 2015, the trust provided 117,703 new adult's outpatient appointments and 194,662 follow up appointments across both hospitals.

During the inspection we visited the outpatient department and diagnostic imaging services at Christchurch hospital.

We spoke with 14 patients and 54 members of staff including, nurses, consultants and other medical staff, physiotherapists, radiographers, occupational therapists, health care assistants, administrators, receptionists and managers.

We reviewed a range of information about the hospital before visiting. Throughout our inspection we reviewed trust policies and procedures, staff training records, audits and performance data. We looked at computerised records and online booking systems. We attended focus groups and listening events, looked at the environment and at equipment being used. We observed care being provided.

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatient and diagnostic imaging services at the hospital as “good” overall.

All areas were given ratings of good for safe and caring services. We found them to be good at providing responsive and well-led care.

At the time of inspection the Christchurch hospital site was undergoing a major re-development and refurbishment program. As a result some outpatient clinics and services had been temporarily relocated around the site whilst work was carried out. This caused disruption to both patients and staff. We observed that risks had been assessed and mitigations put in place to ensure safety was not compromised. For example, a fence had been placed around the temporary radiology building to provide an exclusion zone. All staff and building contractors had been briefed about for the exclusion zone and the reasons not to cross the fence.

The day hospital, outpatients and diagnostic departments were well-organised and visibly clean, and there was no shortage of necessary equipment. Medicines were appropriately managed and stored.

There was evidence of effective multidisciplinary working across the Christchurch hospital site, the Royal Bournemouth Hospital and GPs. Services were planned to meet patient needs. Patients told us there was good access to services and appointments and at times that suited their needs.

Staff demonstrated they were passionate about caring for patients and clearly put the patient’s needs first, including their emotional needs. Our observations were that staff provided a strongly patient-centred focus to their work, no matter how busy they were.

Staff were caring and compassionate and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been actively involved in decisions about their care. There was an interpreter service available for patients whose first language was not English. However, there was no literature immediately available in other languages or other formats, such as large print, unless requested.

Staff spoke positively about the leadership at a local level and the visibility and support of the senior team. Although staff did also mention the lack of visibility of the trust executive team at the Christchurch hospital site.

There was an open culture and staff felt they could make suggestions to improve service for patients. Feedback was actively sought from patients.

Outpatients and diagnostic imaging

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

We rated safe as good.

- Staff demonstrated appropriate knowledge about the trust incident reporting process and felt encouraged to maintain an open and transparent reporting culture. Feedback from incidents was disseminated during team meetings for shared learning purposes to improve patient outcomes.
- There had been two never events in dermatology in the 12 months to April 2015. These had been thoroughly investigated with processes and practices changed as a result. There had been no other serious incidents reported in the 12 months to April 2015.
- In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the care quality commission.
- Infection control processes were followed with trust wide infection control audits and departmental hand hygiene audits completed. Good results had been achieved.
- The environment was visibly clean and well maintained, with all clinical areas providing hand washing facilities and hand gels for patients and staff. Equipment was in good condition and had been tested to ensure it was in working order.
- Medicines were secured and managed correctly. Patient group directions (PGD), which allow trained non-prescribers to administer medicines without prescription, were mostly in date.
- Staff did generally have a good understanding of Duty of Candour or what their roles and responsibilities were in relation to applying it to their everyday practice.
- Mandatory training compliance overall was good, with outpatients and diagnostic imaging staff across both sites achieving between 90% and 98% compliance. This was against a trust wide target of 80%. All clinical staff had achieved level two in safeguarding and there was a member of staff who had attained level three in paediatric safeguarding.

However,

- Infection control performance was not displayed in patient waiting areas.
- Some patient group directions were out of date.

Incidents

- In the day hospital and all outpatient areas, staff were aware of their responsibly to report incidents. Staff reported incidents either via an electronic reporting system or to their manager who then logged the incident on the reporting system. Staff we spoke with were confident to report incidents and challenge poor behaviour by staff at any level, medical or nursing, if they were concerned about poor practice which could harm a person.
- In the diagnostic imaging department there had been no incidents of exposure much greater than intended (MGTI) in the last year. It is a requirement of the legislation that if during an X-ray a patient receives a higher dose of radiation than required, that this is investigated and reported to the appropriate authority. Staff were aware of their responsibilities to report radiation-related incidents and when to report to the Health and Safety Executive (HSE) under the Ionising Radiation Regulations 1999 or to the Care Quality Commission under the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The trust was not an outlier for diagnostic imaging or radiotherapy. The number of reports was within the expected range and was similar to other trusts when compared with the same level of activity.
- Two Never Events had been reported in the dermatology department. They were recorded as wrong patient surgery and wrong site surgery. The trust and the dermatology department took these cases seriously and both were investigated thoroughly. There was evidence that processes and procedures had been changed as a result of these Never Events.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when

things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology.

- Senior staff told us they had received information and understood their responsibilities with regard to the Duty of Candour. The trust offered specific training in relation to Duty of Candour for junior doctors and managers (Band 6 and above). The trust was reviewing how to include this as part of staff mandatory training for all staff. Duty of Candour was followed in both of the Never Event cases.

Cleanliness, infection control and hygiene

- The day hospital, all outpatient areas, waiting rooms and clinical rooms were visibly clean and tidy.
- Hand sanitizer points were widely available to encourage good hand hygiene practice. There were also posters in waiting areas and at the main reception encouraging patients to clean their hands to minimise the spread of infection. The staff were observed to be adhering to 'bare below the elbow' guidance to enable thorough hand washing and prevent the spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety when performing procedures. We saw staff using them appropriately.
- Infection control practices were monitored by the infection prevention and control lead who, staff reported, attended their departments weekly. There was also a lead for infection control in each outpatient area. Regular infection control audits were conducted and a recent hand hygiene audit showed 100% compliance. Staff we spoke with were aware of the outcomes from audits and changes needed to practice, through information sharing at team meetings.

Environment and equipment

- Throughout the Christchurch Hospital site there were on-going re-development and building works. Some clinics had been temporarily relocated during refurbishments. Reasonable adjustments had been made throughout the site to ensure services were maintained and that patients and staff were kept safe. This was done through regular meetings with the trust and the building contractors. An example of this was in diagnostic imaging when all contractors were briefed by the imaging team about not entering the exclusion fence surrounding the temporary x-ray department located in the car park.
- The environment in outpatients and diagnostic imaging was observed to be well maintained, with adequate seating arrangements for patients to sit and wait for appointments, X-rays and scans.
- The waiting areas, consulting and imaging rooms were all wheelchair accessible.
- In diagnostic imaging there was signage to alert patients to potential radiation hazards in relevant areas.
- Diagnostic reference levels (DRL) and local rules guidelines were displayed in imaging rooms.
- The day hospital was suitably equipped, including sufficient moving and handling equipment to enable patients to be cared for safely.
- Equipment was visibly clean. Items we checked were labelled with the last service date and review date and they also had an asset number to enable easy tracking of the item, if it required servicing or maintenance. Portable appliance testing was also undertaken.
- Waste disposal was well maintained by the housekeeping team. There was clear labelling of all clinical waste bins to ensure rubbish was disposed of appropriately.
- We found notice boards throughout the hospital to be overly cluttered and not easy to read.
- Call bells were provided in clinical rooms, should a patient become unwell, with access to support from either that department or the resuscitation team, depending on the severity of the patient's illness.
- Audit of the emergency equipment, by the critical care outreach team, at the day hospital in August 2015 identified all equipment was available in working order and was checked on a daily basis.
- There was no resuscitation trolley as the outpatient department had been designated a public area. There was access to a defibrillator, first aid and anaphylaxis kit.

Medicines

- Medicine cupboards were locked and secured and drug fridges were checked and in order. Fridge temperatures were checked and recorded daily and were in line with national guidance.
- Prescription pads were stored securely in lockable drawers.

Outpatients and diagnostic imaging

Records

- An electronic document management system had been introduced within the trust in the 12 months prior to the inspection. The impact of this for outpatient clinics was that each patient always had an electronic record for their appointment.
- Where patients had historic paper records, these were held securely onsite in the medical records department. Clinics were collated in advance of clinics, with clinic lists reprinted and cross checked the day before, to ensure the records for any patients added more recently to the clinic list were available for their appointment.
- Any patient paper records in the outpatients department were stored in lockable trolleys or kept in the clinic room, to ensure safe storage of records and maintain patient confidentiality.
- Once the outpatient attendance was completed paper records generated or associated with the patient were sent to a central document scanning team, based at Royal Bournemouth Hospital, to be added to the electronic record.
- Medical staff told us that everything they needed was on the system, including diagnostic results, but that the system was slower than they would like due to dated IT equipment.
- Day hospital patients had individual care plans to support safe delivery of care and treatment

Safeguarding

- Staff we spoke with told us they had completed level 2 safeguarding training. They were aware when to raise a concern and the process they should follow but told us they had not had to raise any safeguarding concerns.
- Safeguarding training was provided via an e-learning package and was mandatory for all staff as part of the induction process and updated annually.
- There was a trained nurse who was trained to level 3 and was the safeguarding lead in the department who could provide advice.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction and updated them in line with current policy.
- Mandatory training across outpatients and diagnostic imaging was up to date with a 90% - 98% compliance rate, which exceeded the trust target of 80%.
- The mandatory training package contained a mix of e-learning and face-to-face training, including basic life support, hand hygiene, conflict resolution, and moving and handling. The online training system displayed whether training was out of date by presenting the user with a picture of a brain which was coloured either green (in date) or red (requires review). Line managers were alerted by email when a member of their team was imminently due to renew an element of their mandatory training. This enabled them to monitor staff compliance with their mandatory training requirements.

Assessing and responding to patient risk

- Day hospital patients had an intital multiprofessional assessement of risks and needs and ongoing re assessment during treatment period.
- All staff understood the procedure to follow should a patient collapse or become acutely unwell in the day hospital, outpatient or diagnostic imaging departments.
- In the outpatient and diagnostic imaging departments, Staff were told us that they would measure a patient's vital signs and record them in their notes. We observed that assessments and observations, where necessary, were recorded in the electronic records. The department did not use an assessment tool, for example, the national early warning score, to identify patient's whose condition might deteriorate.
- The phlebotomy clinic had been temporarily re-located and was always held in an appropriate clinic space with chairs designed to lay flat, to ensure appropriate management and support for patients who felt faint and became unwell.
- Within the imaging department, patients were alerted by signs and information in waiting areas where radiation exposure would be taking place. There were also signs and posters to remind women who may be pregnant to inform the radiographer before their x-ray. Radiographers confirmed this with patients as part of the 'pause and check' system to ensure the correct identification of patients prior to imaging. This system was observed to be used in everyday practice.
- The imaging department was located in a temporary building. Risks had been assessed and local rules regarding radiation exposure had been amended accordingly.

Outpatients and diagnostic imaging

Nursing staffing

- There were no set guidelines on safe staffing levels for outpatient clinics. Medical staff confirmed nursing cover was sufficient in all outpatient areas. Senior nursing staff ensured appropriate nurse cover for clinics through daily planning meetings.
- Staff commented that there could be better support for the local nurse managers to allow managers time to take annual leave.
- Outpatient nurse teams had daily meetings to share important updates, such as changes to planned clinics or staffing for the day.
- The day hospital had a stable workforce of nursing staff with minimal use temporary staff. Staff and patients reported there were sufficient numbers of staff on duty to meet the needs of patients in a safe and effective manner

Medical staffing

- Senior nursing staff told us that there were adequate levels of consultant cover for all clinic specialities.
- Consultant appointment times were allied to clinic times.
- Consultants confirmed good working relationships with junior doctors at the trust and within their own teams.
- A GP trainee provided medical cover to the day hospital, under the supervision of a consultant

Major incident awareness and training

- Major incident awareness training was available to all new staff during the corporate induction programme.
- The trust had suitable major incident and business continuity plans in place. A major incident policy was in place for all trust staff and outlined how The Royal Bournemouth and Christchurch NHS Foundation Trust would respond in the event of an emergency (major incident).

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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.

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatients department.

- There was evidence of National Institute for Health and Care Excellence (NICE) guidelines were being followed in outpatients for the rheumatology and dermatology clinics. There was evidence of local audits being undertaken in outpatients and diagnostic imaging.
- Most staff had received an annual appraisal although there had been some delays due to a change in the appraisal system in 2015. Staff felt able to access relevant training to update their clinical skills specific to their roles.
- There was good evidence of multidisciplinary team (MDT) working practices, particularly in the day hospital.
- Most staff had a good understanding around consent procedures and there was good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensured that decisions are made in patients' best interests.

Evidence-based care and treatment

- Day hospital and outpatient services to account of the relevant best practice and National Institute for Health and Care Excellence (NICE) guidelines to treat patients. We reviewed the clinical guidelines for dermatology and rheumatology. They both referred to NICE guidance.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited, including audits against radiation exposure. For example, risks had been assessed and local rules regarding radiation exposure had been amended accordingly. Diagnostic reference levels (DRL) and local rules guidelines were displayed in imaging rooms.

Patient outcomes

Outpatients and diagnostic imaging

- The diagnostic imaging department were considering registering for the national Imaging Services Accreditation Scheme (ISAS) in the future.
- Follow-up to new rate for the trust is higher than the England average for January to December 2014.

Competent staff

- There had been a new values based appraisal system introduced by the trust in 2015 which the staff believed to be a much better and person centred approach.
- Most staff had completed an annual appraisal and documentation was seen to confirm this. Where appraisals had not been completed, line managers provided evidence as to why they were outstanding, for example; where staff had been on maternity or long term sickness absence. 93% of outpatient staff had received their annual appraisal, 97% diagnostic imaging staff had completed their appraisal.
- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed. This was confirmed by staff who felt well supported to maintain and further develop their professional skills and experience. For example; training for staff nurses to develop knowledge to assist in the allergy clinic. Training was also available for staff who wanted to specialise, for example in diagnostic imaging, radiographers were offered training to cover MRI and CT scanning.The day hospital was working with the local university practice development unit to increase the range of competencies of staff through accredited training.
- Teaching sessions regularly took place within diagnostic imaging. The department had a learning file, which contained unusual clinical images. The images were discussed within the teaching sessions to offer staff the opportunity to learn from images that may not be seen again for some time within the department. This session was also used to look at any mistakes that had been made when taking images to ensure that the same errors were not made again.
- The service also provided training for junior doctors within the trust to offer them points to consider when requesting an x-ray, for example that there must be good clinical indicators for an image to be warranted. Nurses were aware of the future requirements for revalidation, the trust held an NMC Revalidation Roadshow.

Multidisciplinary working

- There was effective multidisciplinary working between nursing staff and allied healthcare professionals at the day hospital. They worked with community colleagues to develop individualised care and treatment plans for patients. This included working with GP practices, local social services, community nursing and therapy teams and the local ambulance service provider.
- In diagnostic imaging, staff told us they were well supported by the radiologists. They felt part of one team across two sites. Radiologists came to Christchurch Hospital to report on X Ray images even though this could be done remotely at Royal Bournemouth Hospital. This promoted good team working and provided support and training opportunities to the radiographers.
- Radiographers told us clinicians based at Christchurch Hospital visited their department in person to discuss what imaging was possible in the temporary location. We were told that this led to better quality imaging as radiographers were able to better satisfy the requirements of the clinicians whilst minimising patients to unnecessary radiation.

Seven-day services

- Outpatient appointments were offered Monday to Friday 8am – 5pm.
- Dermatology clinics had extended clinics until 6pm (Wednesday/Thursday) and 8pm (Monday/Tuesday/ Friday) and 8am until midday on Saturday morning.
- The diagnostic imaging department ran an appointment service from 9am until 5pm. There was a walk-in service for GP chest x-ray referrals available from 9am until 4.30pm. Due to the temporary location of the diagnostic imaging at Christchurch hospital the service was not available seven days a week.

Access to information

- Staff we spoke with reported timely access to test results such as from blood tests and diagnostic imaging. Results were available for the next appointment or for certain clinics, during that visit, enabling prompt discussion with the patient on the findings and treatment plan.
- The new electronic document management system ensured that patient notes were always available to ensure continuity of care. Any documents generated

from a clinic appointment were sent to a central department for scanning onto the system. Staff reported some initial delays with this process but it had improved.

- There was an electronic, cross-site imaging results facility. Clinicians could view imaging results on this system if they did not have a copy of the paper report.
- Clinic letters were dictated by consultants at the end of the clinic. They were then typed, scanned on to the hospital electronic record system and a copy sent to the patient's GP. There was evidence that this was completed in a timely manner.
- The day hospital was reviewing patient records so consistent across different aspects of the service. Work was in progress to provide access to community and GP electronic patient record systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were supported to make an informed decision about their treatment prior to giving consent. Information leaflets given to patients included the risks and benefits of the proposed procedure or surgery. Patients were given adequate time at their first appointment to ask questions if needed.
- There was good evidence of consent being sought and comprehensive consent documentation being used.
- Staff completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of the mandatory training programme. Staff we spoke with were aware of how to apply this training, but had needed to use it infrequently.

Are outpatient and diagnostic imaging services caring?

Good

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

We rated caring as good.

- Patients consistently told us that they had experienced a good standard of care from staff across outpatients and diagnostic imaging services.
- Patients at the day hospital spoke highly about the caring manner in which they were treated by all staff.
- During inspection we observed compassionate, caring interactions from nursing, medical therapy and radiography staff. There were good examples of staff supporting patients during clinics. There was excellent positive feedback from the Friends and Family survey data for all services.
- Chaperone signs were displayed in waiting areas and staff were observed asking patients respectfully if they required a chaperone during their consultations to protect their dignity.
- Patients told us that they were included in the decision making regarding their care and treatment and staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.
- Staff provided emotional support and used quiet rooms to speak with patients who had been given bad news. The trust chaplaincy service and chapel was available if required.

Compassionate care

- We observed that staff took all possible steps to promote patient's dignity and they were afforded privacy at all times. We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.
- Reception staff were aware of maintaining patient confidentiality and were observed speaking with patients in an appropriate style.
- Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. Patients told us staff were helpful and supportive.
- Patients at the day hospital spoke highly about the caring manner in which they were treated by all staff.
- Patients were actively encouraged to leave comments and feedback via the use of the Friends and Family Test. The latest Friends and Family test results showed that 97% of patients completing the survey agreed that they would recommend the hospital to family and friends.
- Comments received via CQC feedback cards were overwhelmingly positive about the service provided at the Christchurch Hospital outpatient department.

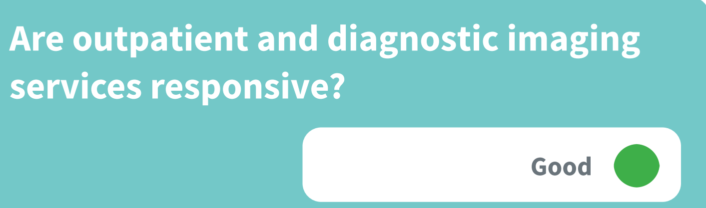
Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they had been provided with the relevant information, both verbal and written, to make an informed decision about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- Outpatients told us there had been sufficient time at their appointment for them to discuss any concerns they had.
- Specialist nurses assisted patients by providing them with additional information and expertise for certain clinics, such as Lupus clinics.

Emotional support

- When having conversations with staff it was clear they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.
- Staff took patients who had been given bad news to quiet rooms.
- The trust chaplaincy service was available to support patients if required. There was a duty chaplain available on site, together with the Christchurch Hospital Chapel which was open 24 hours a day.



By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good.

- Services were planned and delivered in way which met the needs of the local population. Clinics were held on weekdays, with Saturday clinics held for certain specialties. Patients told us that there was good access to appointments and at times which suited their needs.
- Despite on-going building works in and around the hospital patients commented on the pleasant environment and the atmosphere within the hospital. The hospital was accessible for patients in wheelchairs.
- From October 2014 to June 2015, the trust achieved or exceeded the referral-to-treatment (RTT) standard of 92% for incomplete pathways in every month.
- Patients reported clinics generally ran to time. We observed the electronic signs in the waiting room which showed this.
- An interpreter service was available trust wide, which was booked once the patient made staff aware of their requirements.
- The service received very few complaints and concerns. Those that had been received had been resolved locally and informally and changes made as required.

However,

- The referral-to-treatment (RTT) target of 95% of patients who were waiting less than 18 weeks to start treatment that did not involve an admission (non-admitted pathway) had not been met since quarter 3 2014-2015 (October 2014 – December 2014.
- There was no signage available for patients who did not speak English as their first language and no information leaflets were available in any other languages

Service planning and delivery to meet the needs of local people

- The planning for the day hospital and outpatient services was part of a wider plan to develop the hospital as a hub for health services to meet the health needs of the local population and community. This included developing the environment and facilities for outpatients and diagnostic imaging. This work was in progress at the time of the inspection and diagnostic imaging was in temporary accommodation.
- Prior to its move to it temporary location, at the beginning of 2014 the diagnostic imaging team contacted all referring GPs providing detailed information regarding the move. They provided information on what services they could provide and clear instructions about what patients could be referred. This was sent three months prior to the move and then again each month until the move. This ensured that only appropriate patients have been referred to the diagnostic imaging service at Christchurch
- The day hospital was part of the 'Better together project' working with GP practices to develop multi disciplinary teams supporting patients on 'vitual wards' in the community.

- Outpatient appointments were offered Monday to Friday 8am – 5pm.
- The service was planned so each speciality managed their own clinic lists. Outpatients as a department provided the nursing staff and room capacity to meet the needs of the clinic.
- Phlebotomy offered a walk in service from 9am to 3.30pm Monday to Friday. However, to meet regular early morning demand the clinic often opened earlier than planned.
- In order to meet demand dermatology had extended clinics until 6pm (Wednesday/Thursday) and 8pm (Monday/Tuesday/Friday) and 8am until midday on Saturday morning.
- The diagnostic imaging department ran an appointment service from 9am until 5pm. There was a walk-in service for GP chest x-ray referrals available from 9am until 4.30pm.

Access and flow

- In June 2015 3.6% of outpatient appointments across the trust were cancelled each month by the trust, this was better than the England average which was at 7%.
- From October 2014 to June 2015, the trust achieved or exceeded the referral-to-treatment (RTT) standard of 92% for patients who had been waiting less than 18 weeks on a list for referral to treatment (incomplete pathways) in every month.
- The referral-to-treatment (RTT) target of 95% of patients who were waiting less than 18 weeks to start treatment that did not involve an admission (non-admitted pathway) had not been met since quarter 3 2014-2015 (October 2014 – December 2014). The 95% non-admitted target has since been abolished and replaced with the 92% incomplete target.
- There was an electronic display in the waiting room which informed patients of the wait times for individual clinics. The display was updated by clinic staff, during the clinic, to reflect the actual situation within the clinic. 21% of outpatients, across both The Royal Bournemouth and Christchurch hospital sites, waited over 30 minutes to see a clinician. Staff reported that clinics usually start on time. At the time of inspection the trust were carrying out audits of clinic start times in order to understand and potentially improve the flow of clinics.
- Did not attend' rates were consistently below (better than) the England average at 5% (January 2014 – December 2014); the England average was 7%. Phone calls and texts were used to remind patients of appointments.
- The outpatients department had recently undertaken an audit which assessed how many patients did not attend for their appointments. The audit was still ongoing during our inspection.

Meeting people's individual needs

- In clinical areas there was adequate provision to maintain a patient's privacy and dignity. Reception desks were sufficiently away from waiting areas so patients could speak to reception staff, without their conversation being overheard.
- Waiting areas were large and, given the building works that were being undertaken, the signage was appropriate. However, there was no signage available for patients who did not speak English as their first language and no information leaflets were available in any other languages.
- The lack of information in other languages had been previously reviewed by the trust and found not to be an issue based on local population needs. Patients who spoke any other language beside English were provided access to an interpreter. The hospital did have good access to interpretation services once a patients needs were identified. Staff we spoke with confirmed they knew how to access this service but had rarely had to do so.
- The waiting areas, consulting and imaging rooms were all wheelchair accessible.
- Quiet rooms were available should staff need to give patients bad news.
- Where patients with a LD were flagged to any service, the trust LD specialist nurse came to assess the patient and advised the unit/department on helpful strategies.
- Staff gave good examples of where reasonable adjustments were made for patients who lived with dementia. Dementia awareness was part of the trust mandatory training. Nursing and radiography staff told us that if a patient living with dementia became distressed, they would often be prioritised in the clinic list.
- The average care episode in the day hospital was six weeks, but this was dependent on individual need and assessment.

Outpatients and diagnostic imaging

- There was a hospital café and a League of Friends tea shop on site, but no catering facilities within outpatients. A team of volunteers provided refreshments in the day hospital.

Learning from complaints and concerns

- Staff we spoke with were aware of the complaints procedure and who to report any concerns to. Staff told us that learning from complaints was shared at team meetings. Minutes of team meetings showed complaints to be a regular agenda item.
- Information on how to make a complaint was displayed in waiting areas and leaflets were available for patients to take away.
- Across the trust the majority of speciality outpatient complaints related to the length of waiting times once arriving at the hospital for clinic appointments. If a patient complained to nursing staff during clinics, the senior nurse in charge would resolve this issue by discussing the complaint with the patient prior to it escalating.

Are outpatient and diagnostic imaging services well-led?

Good

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.

We rated well-led as good.

- The outpatient department had a strategy that was aligned to the values and vision of the trust. Staff were not aware of how the strategy would develop in their departments but were generally aware of the vision and values of the trust. They were also aware of the developments and changing role of the hospital.
- In diagnostic imaging the 2020 strategy was being planned with staff engagement in moving the strategy forward.
- Governance processes in the outpatient department were at divisional level and were well developed. Information about incidents and patient experience was shared among staff. Risks were collated at service and divisional level. Governance processes in diagnostic imaging were overall, well developed to manage risks and quality.
- Staff in all areas said that their manager was visible and approachable. They told us that they felt well supported and valued.
- Public and patient engagement occurred through feedback such as surveys and comment cards. The day hospital held patient focus groups where patients and their representatives could put forward suggestions for changes and improvements to the service.
- Staff engagement was also encouraged, particularly in diagnostic imaging, where 'seasonal sessions' were held quarterly to gain feedback from staff and to develop the service.
- There was local innovation within outpatients aimed at improving the service for patients. These included a review of outpatient appointment letters to reduce inconsistencies, the introduction of a patient information leaflet to complement the appointment letter and the implementation of a text reminder service for outpatient appointments.

However,

- Some staff at the Christchurch hospital told us how they felt disconnected from the Royal Bournemouth hospital and how they were the 'poor relation'.

Vision and strategy for this service.

- There was a strategy to develop current services and provide the best environment possible for staff and patients. A range of developments and building works had commenced at Christchurch hospital for existing, and new, patient and community services. This was part of the wider strategic plan to provide improve facilities and healthcare for the local community, with the hospital as a hub.
- Senior managers within the outpatient service were developing a plan to improve new patient referral waiting times, which was in line with trust wide strategic objectives.
- The day hospital was integral to the strategy of providing multi disciplinary care for patients with complex and long term conditions in the local community.

Outpatients and diagnostic imaging

- Staff were not clear about any of the specific aspects of the trust wide strategy. However they had been informed of, and had been included in, the Christchurch hospital development plans and strategy.
- Most staff told us that their main vision for the outpatient service was to continue to provide and improve the patient experience. Managers told us that improving clinic capacity to allow more patients to be seen was one of their greatest concerns.
- Staff were aware of the trust wide vision to be the most improved trust in the UK by 2017 and to provide excellent care as they would expect for their families.
- In diagnostic imaging there was a 2020 strategy being developed. Staff representatives had been elected to bring forward ideas from the staff body to be involved in the new strategy development and to participate in moving this forward.

Governance, risk management and quality measurement

- The outpatient department held monthly performance review and risk management meetings attended by all senior staff. Individual specialities also held their own governance meetings, some weekly and others monthly. Governance issues were emailed out to all the outpatient staff, this included patient experience outcomes. Information on clinical risks was shared, but the outcomes from complaints both at local level and trust wide were not always made available to staff.
- Diagnostic imaging services held monthly governance meetings. During these meetings radiation protection issues were discussed. Quarterly radiation protection meetings were held and the minutes from both meetings were disseminated to all staff by email. Staff told us that they felt they were kept up-to-date in relation to governance issues.
- The results of the friends and family test FFT were regularly discussed at development meetings and all comments pertaining to outpatients or diagnostic imaging were monitored.
- The outpatients and diagnostic imaging departments had their own risk registers. Risks were identified and mitigating actions were being taken. Risks specific to specialities were on the speciality risk register.

Leadership of service

- Staff in all areas said that their manager was visible and approachable. They told us that they felt well supported and valued. Staff felt there was a strong family atmosphere and they enjoyed working at the hospital. Staff vacancy, turnover and sickness rates were all low in outpatients and diagnostic imaging.
- Staff at the day hospital described the ward sister and therapy lead as “inspirational”, in their leadership of the service and their on going dedication to improving the service to benefit the local community.
- Most staff reported that the trust executive team and senior management were not very visible at the Christchurch Hospital and they attended meetings only periodically. Senior managers confirmed they held informal staff engagement visits to Christchurch Hospital perhaps twice a year.
- Nursing staff felt well supported by their immediate line managers. They felt that there was a strong leadership presence locally within the department.
- Radiographers felt well supported and valued by their immediate supervisors and their senior management team. Radiographers felt confident they could approach their direct supervisors with any concerns or feedback they might have, and that it would be acted upon fairly and professionally.
- Senior nursing and therapy day hospital staff attended professional and medical directorate governance meetings at Royal Bournemouth Hospital site.

Culture within the service

- All staff we spoke with at Christchurch Hospital confirmed how proud they were to work at the site. There was an overwhelming sense of community spirit with staff based at, or who rotated from the Royal Bournemouth Hospital to Christchurch Hospital.
- We observed staff supporting each other to ensure the best possible service was provided for all patients.
- Most staff reported that they felt Christchurch Hospital was the ‘poor relation’ to the Royal Bournemouth Hospital. For example, IT support could be given by telephone helpline at any time however staff reported limited access to IT engineer support, with IT staff only visiting the site on Tuesdays.

Public engagement

- Engagement with patients was encouraged by the departments. Feedback was sought by survey, comments cards and the friends and family test results.

'You said, we did' boards were displayed in some patient waiting areas. Comments cards and patient satisfaction surveys had taken place within outpatients and diagnostic imaging.
- Patient engagement meetings were held annually to encourage patients to have a voice in shaping their services.
- The day hospital had a patient focus group where patients and their representatives could put forward suggestions for changes and improvements to the service.
- Public and patients were kept informed of the on-going developments at Christchurch hospital by a quarterly factsheet produced by the trust. The factsheet was on the trust website together with previous factsheets and the original re-development plans for reference.

Staff engagement

- The trust had a variety of ways to recognise and congratulate outstanding contributions and achievements from members of staff. A trust employee could be nominated by another member of the trust, or by a member of the public. This prompted local 'thankyou awards' as well as trust wide recognition. Staff told us they felt proud to have colleagues from their hospital as nominees or award winners.
- Staff felt included in decisions around changes to services in their department and the hospital.
- Staff were kept informed of the on-going development works at Christchurch hospital through feedback from meetings with building contractors. A quarterly trust factsheet providing details of the on-going developments was also made available to staff via the trust website.
- In diagnostic imaging, staff engagement was apparent. All radiology staff were invited quarterly 'Seasonal Sessions'. Staff were asked to participate in discussion regarding the future plans for the service as well as educational topics. Staff told us that they felt engaged within the department and regularly asked for their opinions during team meetings to improve practice.
- In outpatient departments staff generally felt engaged. Staff attended meetings where information was shared and discussions held about the service, what concerned staff and how the department could be improved.

Innovation, improvement and sustainability

- At the day hospital, there was an embedded culture of supporting staff to partake in projects to improve services and develop their own skills and knowledge. At the time of the inspection, there were a total of 88 different projects of varying sized with the aim of improving day care service leading to admission prevention and increase of patient independence. There was an understanding across the day hospital that "nothing is too small to contribute" to the service.
- The outpatient department reviewed its outpatient appointment letters and reduced a number of inconsistencies and the number of letter templates. Following the review outpatients have implemented standardised, clear and easy to read letters.
- The outpatient department implemented a patient information leaflet to complement the outpatient appointment letter sent to patients prior to their appointment.
- Quality Improvement Fellowship programmes had been introduced, one of such innovation was for text reminders for outpatients appointments to reduce DNAs.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

The hospital should ensure:

- There is consultation on the overarching end of life strategy, with internal and external stakeholders.
- Where relevant, mental capacity assessments are completed on the DNACPR forms.
- All policies within end of life care service are reviewed and updated as planned.
- A formal clinical audit programme is put in place at the hospital.
- Staff appraisals are completed, to reach trust targets.
- Staff complete mandatory training, to reach trust target levels.
- Nutritional screening is completed for patients on admission to the Macmillan unit.
- Medical records are stored more securely, in locked trolleys and /or secure offices to prevent unauthorised access.
- Timeliness of communication between end of life care services and the district nursing team.
- Documentation of the efficacy of pain relief given to patient in end of life care.
- Monitoring of all a patients with a delayed discharge is reviewed.
- Oxygen cylinders in a location on the Macmillan inpatient unit where they are not a trip hazard.
- Review the processes in place for monitoring the fridge temperature in the mortuary.
- Improve the general decoration of the mortuary viewing room, if it continues to be used.
- Review notice boards throughout outpatient departments at Christchurch Hospital to ensure clear and consistent information is provided.
- Trust senior management are more visible at Christchurch Hospital.