

# Dartford and Gravesham NHS Trust

## Inspection report

Darent Valley Hospital  
Darent Wood Road  
Dartford  
Kent  
DA2 8DA  
Tel: 01322428100  
www.dvh.nhs.uk

Date of inspection visit: 7 Nov to 7 Dec 2017  
Date of publication: 28/03/2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Requires improvement 

Are services safe?	Requires improvement 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Requires improvement 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

# Summary of findings

## Background to the trust

Dartford and Gravesham National Health Service trust provides a range of acute services across Kent to approximately 350,000 people a year.

The trust has around 463 inpatient beds and provides specialty services including, day-care surgery, general surgery, trauma, orthopaedics, and cardiology, maternity and general medicine.

The trust has a team of around 2,000 staff. The local population continues to grow significantly in this area. This has a direct impact on the increasing demand on the services provided by the trust.

This trust has five registered locations:

- Darent Valley Hospital
- Gravesham Community Hospital
- Queen Mary's Hospital
- Erith & District Hospital
- Elm Court

## Overall summary

Our rating of this trust stayed the same . We rated it as **Requires improvement**   

## What this trust does

Dartford and Gravesham National Health Service trust provides a range of acute services across Kent to approximately 350,000 people a year.

The trust has around 463 inpatient beds and provides specialty services including, day-care surgery, general surgery, trauma, orthopaedics, and cardiology, maternity and general medicine. area. This has a direct impact on the increasing demand on the services provided by the trust.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

# Summary of findings

On 7 and 8 November 2017, we inspected four of the core services provided by Dartford and Gravesham National Health Service trust. At our last inspection, two of these core services (urgent care and surgery) were rated as requires improvement. We had concerns about medicine and maternity both of which were rated good in 2013.

Our comprehensive inspections of National Health Service trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at trust level. Our findings are in the section headed 'Is this organisation well-led?' We inspected the well-led key question on 6 and 7 December 2017.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement.

### Are services safe?

Our rating of safe went down. We rated it as requires improvement because:

- Overall the safety domain in urgent care, surgery, medicine and maternity was rated as required improvement. This meant that improvements were needed to safeguard patients from the risk of receiving unsafe care.
- Patients were not protected from the risk of healthcare acquired infections because national and trust guidance was not being consistently adhered to.
- There was a lack of robust infection control compliance monitoring. Trust quality monitoring data was not consistent with our inspection findings. Clinical areas were not always clean and infection prevention methods were not consistently used.
- Emergency equipment was not consistently checked in line with trust policy.
- Staffing in maternity was unsafe due to the midwife to birth ratio of 1:36 which is not in line with Birth-Rate Plus staff guidance.
- In urgent and emergency care we found insufficient safeguarding processes which did not protect vulnerable adults or children from the risk of abuse.
- Systems and processes to prevent recurrence from patient safety incidents were not effective because there was a lack of learning at departmental or trust wide level.
- The standard of record keeping lacked consistency and varied greatly across the trust.
- Records were not always stored securely or kept confidential.
- In urgent and emergency care and surgery compliance with Mental Capacity Act Training was poor. This meant staff may not have awareness if patients lacked mental capacity to make decisions; or understand best interests decisions or awareness of the Mental Capacity Act 2005

### Are services effective?

Our rating of effective went down. We rated it as requires improvement because:

- Surgery, medicine and urgent care were rated as requires improvement for the effective domain. The maternity core service was rated as good.

# Summary of findings

- In medicine, consultants did not always work in a shift pattern that promoted continuity of care. This had led to delayed discharges and patients being reviewed twice unnecessarily.
- In medicine, urgent care and surgery trust performance in the national audit programme showed varied performance when benchmarked against other trusts.
- The medical directorate did not routinely undertake clinical supervision to ensure staff competencies were up to date.
- In urgent care Mental Capacity and Deprivation of Liberty safeguards was not widely understood by staff.
- Staff in theatres did not have the required knowledge, training and skills to care for children.
- In surgery, there was not a process which ensured staff had the necessary skills and competence to perform their role within theatres. Ongoing competence was not reviewed and therefore not assured.

## Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- We observed patients being treated with compassion, by kind and professional staff who put patients at the heart of the service they delivered.
- Patients were treated with dignity and were involved in planning and making decisions about their care.
- Emotional support was provided to patients, and their relatives.
- Patients told us the care they received met their individual needs and respected their wishes.
- The feedback we received from patients and their loved ones showed high levels of satisfaction with the services.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Access and flow throughout the trust presented as a daily operational challenge.
- In urgent care and medicine, patients did not always have their individual care needs taken into consideration.
- There was a notable increase in medical outliers in medical care.
- In surgery relatives, staff and the internet were used to translate for patients who did not speak English. The use of family, friends or unqualified interpreters is strongly discouraged in national and international guidance and is not considered good practice. The trust had translation services available however staff said they avoided using them when they could to reduce cost.
- In surgery systems and processes to learn and improve from complaints was not effective.
- Overall, we found the service provided by the maternity service was responsive to individual needs and was rated as Good.

## Are services well-led?

Our rating of well-led went down. We rated it as requires improvement because:

- There was a lack of clarity regarding the structure amongst executive teams, middle managers and staff. From an accountability perspective a lack of understanding of structure leaves the organisation vulnerable.
- We found that the board was not always assured of safety and quality through its governance structures. Although there was a governance structure in place inspection findings showed that it was not effective.

# Summary of findings

- Although the trust had an overarching strategy there was no current nursing or quality strategy, but plans were in place to refresh this following our inspection.
- The trust had identified a gap in oversight and told us there was a need for a Head of Nursing role within directorate management teams in order to strengthen nursing leadership and governance processes.
- Key nursing metrics did not form part of the performance reporting framework, but these were being developed at ward level.
- We were not assured that there was a consistent and embedded approach to learning from incidents. We found pockets of learning were demonstrated but that this learning had not been shared trust wide. We also found that staff were not always following the trust policy and reporting relevant incidents.
- The trust had a patient engagement strategy plan in place but at the time of inspection this had not been embedded into practice.

However:

- The leaders had the skills, knowledge, experience and integrity to lead the trust. The trust board members we met were a group of individuals with a wide range of experience, knowledge and skills, although most relatively new to their posts.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities.
- The trust's strategy, vision and values underpinned a culture which was patient centred. The leadership culture in the trust was described by the Chief Executive Officer as 'very focussed on getting it right for the patient', and 'friendly organisation where people felt free to express ideas and concerns'.
- Most staff reported feeling supported, respected and valued. Staff felt able to raise concerns without fear of retribution. The trust had appointed a Freedom to Speak-up Guardian and had a number of routes to enable staff to raise concerns.
- The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust had been working with both the South East London and Kent and Medway sustainability and transformation plans.
- External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. The trust worked with Guy's and St Thomas' National Health Service Foundation Trust with their Vanguard initiative.

## **Darent Valley Hospital**

At Darent Valley Hospital we inspected the core services of medicine, surgery, urgent and emergency care and maternity care.

## **Elm Court**

At Elm Court we only inspected medicine (including older people's care). The service was rated as Requires Improvement overall.

## **Queen Mary's Hospital**

At Queen Mary's Hospital we only inspected surgery. The service was rated as good overall.

# Summary of findings

## Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in urgent care, maternity and the surgery services throughout the trust.

For more information, see the Outstanding practice section in this report.

## Areas for improvement

We found 27 things the trust **MUST** improve to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found 31 areas the trust **should ensure**, and 16 areas the trust **should consider** to improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

## Action we have taken

We have taken enforcement action against the trust. That meant the trust had to send us a report saying what action it would take to meet the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our action related to breaches of legal requirements in the core services we inspected.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

### Darent Valley Hospital

#### Urgent and emergency care:

- A pharmacist was supported to develop their scope of practice by becoming an advanced practitioner. This role provided additional support with the assessment of patients with minor illnesses and was a positive example of innovation in the department.
- There was a system in place to monitor and safeguard vulnerable patients with mental health problems who frequently attended the department. There was multidisciplinary oversight ensuring these patients and their individual health and social needs were met.
- A member of staff who was involved in a major incident at another trust had learned from an experience the difficulty crossing a police cordon without an Identity badge. The majority of staff kept their badges in their work lockers. If a major incident occurred whilst they were not on duty, they would not be able to cross the cordon. To overcome this, staff were issued with a second identity badge to keep at home.

# Summary of findings

## Maternity:

- There were comprehensive training and education opportunities available to staff from the maternity education team. This included midwives completing a midwife core competencies handbook, where evidence of competence was documented.
- Maternity services employed an audit midwife. The audit midwife was involved in the Phoenix trail, the trial was looking at whether delivery in women with pre-eclampsia between 34 and 36 weeks of gestation reduced maternal complications without short and long-term detriment to the infant compared to expectant management and delivery at 37 weeks of gestation.
- The delivery suite was involved in 'the safety culture, quality improvement and realistic evaluation project in 2016 and 2017. The project was an evaluation study to identify effective strategies of working in particular settings. Work was still in progress on the project at the time of inspection.

## Surgery:

- The theatre team had developed a video of the correct way to perform the World Health Organisation safer surgery checklist this was in response to a Never Event. The video was due to be shown to all theatre staff, surgeons and anaesthetists on an educational afternoon.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

## Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with legal requirements. This action related to the four core services we inspected and the trust overall.

## Overall trust

The trust **MUST** have a strategy in place in relation to Mental Health Act 2015 administration and compliance.

## Darent Valley Hospital

### Urgent and emergency care:

- The trust **MUST** review its safeguarding processes in urgent care to ensure that patients are protected against the potential risk of abuse. This must include obtaining assurance that all staff can identify and report a safeguarding concern and demonstrate learning from generating alerts.
- The trust **MUST** ensure it has effective systems processes to gain assurance that all temporary staff have pre-employment and professional registration checks undertaken, (including professional registrations).
- The trust **MUST** ensure patients' data and records are stored safely, securely and kept confidential at all times.
- The trust **MUST** ensure it provides care to patients that respects their confidentiality and promotes their dignity and avoids mix sex breaches in Cypress ward.
- The trust **MUST** ensure a consistent and contemporaneous records for all patients', which includes a rigorous audit process to monitor compliance.

# Summary of findings

- The trust **MUST** ensure that all emergency equipment is available and checked in line with trust policy.
- The trust **MUST** all staff adhere to the trust policy and national infection, control and prevention guidance. The effectiveness of infection control practices should be regularly monitored and acted upon to provide assurance that patients are protected from the risk of contracting health acquired infections.

## Medicine:

- The trust **MUST** ensure that escalation beds are fit for purpose and that all patients are cared for in a safe environment, particularly on Chestnut ward.
- The trust **MUST** ensure it addresses mixed sex breaches across the medical service.
- The trust **MUST** ensure it develops the audit activity to develop an effective process to assure quality.
- The trust **MUST** review its safeguarding training in medical care to ensure that patients are protected against the potential risk of abuse. Staff must have the required level of safeguarding training to comply with national guidelines.
- The trust **MUST** ensure patients' data and records are stored safely, securely and kept confidential at all times.
- The trust **MUST** ensure it provides care to patients that respects their confidentiality and promotes their dignity and avoids mixed sex breaches in medical care.
- The trust **MUST** ensure in medical care that a consistent and contemporaneous record for all patients' records must be stored securely and notes need to be secured in folders.

## Surgery:

- The trust **MUST** ensure patients confidentiality, dignity and respect is maintained within theatres
- The trust **MUST** ensure all staff adhere to the trust policy and national infection, control and prevention guidance.
- The trust **MUST** ensure patients records are filed correctly, fully completed, stored safely, securely and kept confidential at all times.
- The trust **MUST** ensure patient risk assessments are undertaken to ensure correct action is taken to mitigate risks.
- The trust **MUST** ensure that all equipment is available and checked in line with trust policy and national guidance.
- The trust **MUST** ensure a contemporaneous care plan and nursing evaluation is maintained.

## Maternity

- The trust **MUST** ensure obstetric theatre nurses 24 hours a day seven days a week to ensure midwives are not redeployed away from designated areas and other women.
- The trust **MUST** ensure the midwife to birth ratio meets the national requirements.
- The trust **MUST** ensure sufficient consultant cover on the delivery suite with defined working hours.

## Queen Mary's Hospital

### Surgery:

- The trust **MUST** ensure patients confidentiality, dignity and respect is maintained within the theatre holding bay at Queen Mary's Hospital.
- The trust **MUST** ensure it has effective processes in place which ensures agency staff have the correct skills, knowledge, qualifications and competence to carry out their role within theatres Queen Mary's Hospital.

# Summary of findings

## Elm Court

### Medicine:

- The trust **MUST** ensure it is compliant with the National Specifications for Cleanliness at Elm Court and ensure a cleaning strategy and operational plan are in place.

## Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

## Darent Valley Hospital

### Urgent and emergency care

- The trust **should ensure** a review of mandatory training compliance. This should provide assurance that all staff have received the required level of training to be able to meet people's needs. This should also incorporate a review of the trust wide systems and processes to track training compliance.
- The trust **should ensure** an effective nursing assessment tool is implemented to help staff to quickly determine the level of risk, manage flow in a department given the high patient turnover and increased reliance on temporary workforce.
- The trust **should ensure** it develops a healthy audit culture, and effective local audit process to monitor and improve the quality of care.
- The trust **should ensure** it reviews the environmental risk assessment documentation, ward environment and patient criteria, for Cypress ward.
- The trust **should ensure** all patients transferred to Cypress ward have a handover and completed documentation in place. Compliance needs to be monitored through regular audit cycles.
- The trust **should ensure** it reviews medical and nurse staffing to ensure there is sufficient cover and skill mix to meet the needs of the service. This process would ideally include staff feedback about acuity, workload, skill mix and safety of the resus, and overflow areas.
- The trust **should ensure** it reviews the staffing arrangements in the main reception area.
- The trust **should ensure** there is a consistent approach to infection control and prevention in the department to safeguard patients from the risk of health acquired infections.
- The trust **should ensure** that there is effective learning from incidents, safeguarding and complaints processes to drive quality and improve the service provided.
- The trust **should ensure** a regular and formal process for Mortality and Morbidity meetings.
- The trust **should ensure** it develops emergency department specific policies and procedures which are reviewed regularly.
- The trust **should consider** strengthening its multi-disciplinary approach to care in the emergency department.
- The trust **should consider** strengthening its focus on nurse leadership development and departmental structure.
- The trust **should consider** addressing the low staff morale and improve staff engagement processes.
- The trust **should consider** involving all staff at all grades in any future department consultations.

# Summary of findings

- The trust **should consider** ways to improve and strengthen relationships and support from other hospital departments.
- The trust **should consider** reviewing the effectiveness of governance and risk management processes.
- The trust **should consider** it reviews the current IT access rights for its temporary staff to improve departmental effectiveness, and reduce the burden on permanent staff.

## Medicine

- The trust **should ensure** it reviews medical and nurse staffing to ensure there is sufficient cover, consistency and skill mix to meet the needs of the service.
- The trust **should consider** a review the maintenance of equipment and ensure staff are aware of trust policy.
- The trust **should consider** involving all staff at all grades in any future department consultations.
- The trust **should consider** reviewing the current Information Technology access rights and training for its temporary staff in medical care, to improve departmental effectiveness and reduce the burden on permanent staff.

## Surgery

- The trust **should ensure a** review of mandatory training compliance. This should provide assurance that all staff have received the required level of training to be able to meet people's needs.
- The trust **should ensure** that there is effective learning from incidents and complaints.
- The trust **should ensure** a regular and formal process for Mortality and Morbidity meetings.
- The trust **should** ensure substances that could cause harm are stored securely.
- The trust **should** ensure staff have the correct level of safeguarding training.
- The trust **should** ensure only interpreters employed by the trust are used for translation.
- The trust **should** ensure patients operations are prioritised in line with national guidance.
- The trust **should** ensure it has effective processes in place which ensures staff have the correct skills, knowledge and competence to carry out their role within theatres.

## Maternity

- The trust **should ensure** the mandatory training spreadsheet accurately reflects training compliance in the department.
- The trust **should ensure** the 'strategic and operational cleaning plan' is reviewed and updated if required.
- The trust **should ensure** the drain covers and exposed wood and sealant should be repaired in Aspen ward.
- The trust **should ensure** an operating department practitioner, provides 24 hour cover, seven days a week to support anaesthetists.
- The trust **should ensure** decisions for caesarean section should be discussed with a consultant.
- The trust **should ensure** consultant staff are visible and accessible on the labour ward.
- The trust **should ensure** records are scanned to the electronic health records system without delay and available to staff at all times.
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# Summary of findings

- The trust **should ensure** governance meetings should be minuted and have a record of what was discussed and who was responsible for any actions or decisions.
- The trust **should ensure** the risk register should contain timescales for when identified actions should be completed.
- The trust **should ensure** learning from incidents are disseminated in a timely manner and without delay.
- The trust **should consider** reviewing the security of the maternity unit.

## Queen Mary's Hospital

### Surgery

- The trust **should consider** ways to improve and strengthen relationships and leadership in departments and Queen Mary's hospital.
- The trust **should consider** the use of a sepsis pathway and policy.
- The trust **should consider** reviewing the effectiveness of governance and risk management processes.
- The trust **should consider** how policies and procedures at Queen Mary's Hospital are aligned with Darent Valley Hospital.

## Is this organisation well-led?

Our comprehensive inspections of National Health Service trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated the well-led domain at the trust as requires improvement because:

- There was a lack of clarity regarding the structure amongst executive teams, middle managers and staff. From an accountability perspective a lack of understanding of structure leaves the organisation vulnerable.
- We found that the board was not always assured of safety and quality through its governance structures. Although there was a governance structure in place inspection findings showed that it was not effective.
- Although the trust had an overarching strategy there was no current nursing or quality strategy in place. The Director of Nursing had plans to refresh the quality strategy (published 2015/2016) following the findings in our core service reviews. The Director of Nursing recognised a gap in oversight and told us there was a need for a Head of Nursing role within directorate management teams in order to strengthen nursing leadership and governance processes.
- Key nursing metrics did not form part of the performance reporting framework. Balanced scorecards/ward dashboards for nursing were being developed but had not yet reached the stage of benchmarking. The trust were working towards an integrated scorecard, some departments had made good progress with this for example, maternity and urology.
- Governance arrangements were not in place in relation to Mental Health Act 2015 administration and compliance. The trust did not have a mental health act strategy and a paper had not been presented to board. The Director of Nursing was planning to present a paper to board in the next quarter.

# Summary of findings

- The equality and diversity workforce report June 2017 suggests the trust could take more action to support its aim to be an employer of choice and more reflective of its local population. Staff networks were not in place promoting the diversity of staff.
- We had mixed feedback on whether managers addressed poor staff performance where needed. Some staff and directors felt that the family environment at the trust sometimes prevented challenge and difficult conversations.
- We were not assured that there was a consistent and embedded approach to learning from incidents. We found pockets of learning were demonstrated but that this learning had not been shared trust wide. We also found that staff were not always following the trust policy and reporting relevant incidents.
- There were arrangements to ensure the availability and integrity of identifiable data, records and data management systems in line with data security standards. However, there was a lack of staff supervision of confidential patient information in some areas. During our unannounced inspection in November 2017, we found breaches in patient confidentiality across urgent and emergency care, surgery and medicine.
- The trust had a patient engagement strategy plan in place but at the time of inspection this had not been embedded into practice. Involvement of patients with any of the nine protected characteristic was being developed in line with the strategy. There was no data collected from patients with protected characteristics such as sexual orientation, civil partnership and gender reassignment. There was a diversity management group and we were told they would be discussing how this data could be collected in the future.

However:

- The leaders had the skills, knowledge, experience and integrity to lead the trust. The trust board members we met were a group of individuals with a wide range of experience, knowledge and skills, although most relatively new to their posts. We found that the newer members of the executive team demonstrated a good insight into the organisation and a drive to take the trust forward.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust had developed a pictorial representation of its vision and strategy along with its sustainability and transformation plans. From this the trust had developed its values of care with compassion, respect and dignity, striving to excel, professional standards and working together along with a behaviour framework
- The trust's strategy, vision and values underpinned a culture which was patient centred. The leadership culture in the trust was described by the Chief Executive Officer as 'very focussed on getting it right for the patient', and 'friendly organisation where people felt free to express ideas and concerns'. Staff we spoke with during inspection all reflected that they cared and were focussed on providing good experiences of care for patients.
- Most staff reported feeling supported, respected and valued. We met with different groups of staff including consultants, junior doctors, nurses, allied health care workers and support staff. Most said the trust was supportive to them. Staff described a friendly and supportive working environment. We saw supportive interactions from staff throughout our inspection. Staff reported feeling proud to work for the organisation.
- Staff felt able to raise concerns without fear of retribution. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. The trust had appointed a Freedom to Speak-up Guardian and had a number of routes to enable staff to raise concerns. We saw that the trust advertised methods for raising concerns on the intranet and on ward posters and newsletters.
- The trust applied duty of candour, as evidenced within our review of documents pertaining to adverse events and serious incident investigations. They took learning and action as a result of concerns raised, and were open and honest in their communications to individuals concerned.

# Summary of findings

- The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust had been working with both the South East London and Kent and Medway sustainability and transformation plans.
- External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. The trust worked with Guy's and St Thomas' National Health Service Foundation Trust with their Vanguard initiative. This acute care collaboration with Guy's and St Thomas' NHS Foundation Trust had seen improvements in care delivery in a number of areas including vascular surgery, paediatrics and cardiology.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ 2018	Requires improvement ↓ 2018	Good ↔ 2018	Requires improvement ↔ 2018	Requires improvement ↓ 2018	Requires improvement ↔ 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

### Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Darent Valley Hospital	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↔ Mar 2018
Queen Mary's Hospital	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Elm Court Ward	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
<b>Overall trust</b>	Requires improvement ↓ 2018	Requires improvement ↓ 2018	Good ↔ 2018	Requires improvement ↔ 2018	Requires improvement ↓ 2018	Requires improvement ↔ 2018

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Darent Valley Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Mar 2018	Requires improvement Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018
Medical care (including older people's care)	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018
Surgery	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018	Good ↑ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↔ Mar 2018
Critical care	Good Jul 2014	Good Jul 2014	Good Jul 2014	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014
Maternity	Requires improvement ↓ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Jul 2018	Good ↔ Jul 2018
Services for children and young people	Good Jul 2014	Good Jun 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
End of life care	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jun 2014	Good Jun 2014
Maternity and gynaecology	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Outpatients and diagnostic imaging	Good Jul 2014	Not rated	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
<b>Overall*</b>	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↔ Mar 2018

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Queen Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement Mar 2018	Good Mar 2018				
<b>Overall*</b>	Requires improvement Mar 2018	Good Mar 2018				

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

### Ratings for Elm Court Ward

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
<b>Overall*</b>	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Elm Court Ward

Watling Street  
Dartford  
Kent  
DA2 6EG  
Tel: 01322515862

## Key facts and figures

The trust uses beds in Priory Mews, a care home in Dartford. The area used by Dartford and Gravesham NHS trust is Elm Court and is used for the medically fit patients who require a short period of rehabilitation, assessment and mobilisation.

## Summary of services at Elm Court Ward

### Requires improvement

We have not inspected this location before. We rated it as requires improvement because:

- We inspected medical care – the only service provided here – and rated it as requires improvement.

# Medical care (including older people's care)

**Requires improvement** ●

## Key facts and figures

The trust uses beds in Priory Mews, a care home in Dartford. The area used by Dartford and Gravesham NHS trust is Elm Court and is used for the medically fit patients who require a short period of rehabilitation, assessment and mobilisation.

The extra beds aim provide an alternative environment for those ready to leave hospital and free up beds for those requiring acute surgical or medical admission at Darent Valley. It has an on-site dedicated physiotherapists and occupational therapists with full hospital support.

## Summary of this service

We have not previously rated this service. We rated it as requires improvement because:

- Mandatory training figures were below trust targets and staff did not have sufficient safeguarding training.
- We saw poor compliance with infection control policies and maintenance of equipment. At Elm Court there was no cleaning strategy or operational plan. Both these documents are a requirement of the National Specifications for Cleanliness in the National Health Service.
- Staffing had improved but was still under the planned levels for several months leading up to inspection.
- Patient records at Elm Court did not meet national requirements with overfilled folders and loose pages. Records were not securely stored.
- Safety thermometer information was being collected but not used effectively to improve services.
- Patients were placed in Individual bedrooms, these were not always ideal for supporting patient's needs.
- Patients were sometimes referred inappropriately. However, a new system of risk assessment, based on traffic lights had recently been introduced to prevent inappropriate referrals and admissions.
- The unit was not dementia friendly. Although dementia patients were not routinely admitted, the operational policy allowed patients with dementia to be cared for on the unit.

## Is the service safe?

**Requires improvement** ●

We rated it as requires improvement because:

- Mandatory training figures were not in-line with trust targets. Staff did not have the required level of safeguarding training. Figures for level one and two safeguarding training were much worse than trust targets.
- We saw some poor compliance with infection control policies at Elm Court. The service did not always control infection risk well and found areas of the unit that were not clean. There was no cleaning strategy or operational plan. Both these documents are a requirement of the National Specifications for Cleanliness in the National Health Service.
- Audit results were not routinely used to improve services and were not always effective.

# Medical care (including older people's care)

- We saw some poor management of medical equipment and Control of Substances Hazardous to Health. Monitoring whether safety systems were implemented was not robust and we had concerns about the consistency of staff awareness and understanding of them.
- There was a high staff vacancy rate resulting in high agency use at Elm court. This had led to staff skill mix not always being appropriate and regular staff feeling overworked.
- Patient records at Elm Court did not meet national requirements with overfilled folders and loose pages. Records were not securely stored.
- It was not clear how the service was using safety monitoring results to improve the service.
- Staff we spoke to were not aware of any incidents from Darent Valley Hospital which could indicate that feedback was not routinely given.
- The environment at Elm Court was not always well maintained and we saw lots of equipment in inappropriate places like the main lounge and dining area. The cluttered environment could be confusing for patients with dementia or special needs and could also cause a trip hazard for patients with limited mobility.

However:

- Risk assessments were carried out on patients on arrival and throughout their stay. These ensured patients were identified early should their condition have deteriorated.

## Is the service effective?

**Good** ●

We rated it as good because:

This is the first inspection of these services. We rated it as good because:

- Patients with complex needs received prompt screening by a multi-disciplinary team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff.
- Clear multidisciplinary assessment was undertaken and care plans were put in place from admission.
- Staff appraisals were in line with trust targets with 86% of staff having received an appraisal within the last 12 months.
- Staff we spoke with had good awareness of what to do if patients lacked the mental capacity to make decisions; they understood best interests decisions and showed good awareness of the Mental Capacity Act 2005.

However;

- There was no longer a practice development nurse for the department staff reported this had negatively impacted their training opportunities and competency checks.
- The directorate did not routinely undertake clinical supervision to ensure staff competencies were up to date.
- There was no formal pain scoring used for patients with severe communication difficulties. Staff told us they use facial expression for pain scoring in these cases. However, that could lead to inconsistent scoring of patients' pain as different staff may not notice a difference from day to day.

# Medical care (including older people's care)

## Is the service caring?

**Good** ●

We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff understood and respected the personal, cultural, social and religious needs of patients; we witnessed these being discussed in relation to their care needs.
- Staff showed they understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them.

Family members and carers were involved in all discussions around a patient's care.

## Is the service responsive?

**Good** ●

We rated it as good because:

- There was a new system of risk assessment, based on traffic lights which had recently been introduced to prevent inappropriate referrals and admissions. It set clear criteria for transfer to Elm Court and aimed to avoid inappropriate admissions. Staff at Elm Court were involved in developing the criteria.
- The trust had identified a further ward at Darent Valley Hospital to work alongside Elm Court and take patients who were medically fit for discharge. This aimed to improve flow and was in response to patient demand.
- The staff at Elm Court had access to the advice of an identified doctor based in Darent Valley Hospital and an out of hours on-call medical team, ensuring patients can access a doctor if their condition deteriorates.
- Patients with complex needs had services to support them throughout discharge. An example of this is the 'Hospital at Home' service, where teams would visit patients who required medical care such as Intravenous antibiotics, at home to aid discharge from Elm Court.
- Elm Court Operational policy (2013) instructs staff what to do if a patient's health was deteriorating. We felt some aspects of the policy could have been strengthened to give staff specific indicators for clarity. However there were no reported incidents that would suggest deteriorating patients were not managed appropriately.

However;

- Adjustments had not been made for patients living with dementia. There were no environmental amendments in place or specialist equipment for example coloured cutlery, toilet seats or dementia friendly signs.

## Is the service well-led?

**Requires improvement** ●

We rated it as requires improvement because:

# Medical care (including older people's care)

- The trust were told to improve on aspects of the medical care service they delivered during our previous inspection in 2015. These had not always been addressed and showed a lack of commitment by the leadership team to implement the recommendations. Examples included poor information governance and infection control practices.
- The hospital had recently implemented a new model of care that brought the emergency care directorate and adult medicine into one directorate. This included all staff under one umbrella. Less senior staff we spoke with were unclear of the new structure and showed limited knowledge of the impact it would have on the department.
- Apart from the senior staff there was not a clear vision and a set of values that staff recognised. We saw posters with the values displayed on wards, but staff could not repeat these to us and did not have a clear idea of any departmental plans for the future.
- Although there were effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services, these were not effectively reviewed to ensure safe practice. For example cleaning audits were not consistent with what we witnessed on inspection.
- We saw several breaches of patient confidentiality. Staff did not ensure that confidential information was not seen or overheard by others, and patient records were not held securely.

However:

- Staff at Elm Court were consulted on a recent system of risk assessment, based on traffic lights which had recently been introduced to prevent inappropriate referrals and admissions.
- We saw supportive interactions from staff throughout our inspection. Several staff from many different areas reported feeling proud to work for the organisation.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Queen Mary's Hospital

Frognal Avenue  
Sidcup  
Kent  
DA14 6LT  
Tel: 0208 3022678

## Key facts and figures

This hospital provides only low risk surgery services. See below for more information.

## Summary of services at Queen Mary's Hospital

**Good** 

**We have not rated this hospital before. We rated it as good because:**

- It provides only surgery services, which we rated as good.

# Surgery

Good 

We have not rated this service before. We rated it as good.

## Key facts and figures

Surgical services at Dartford and Gravesham trust provide elective day- stay and inpatient care. The specialities covered are general surgery, gynaecology, orthopaedic and ear nose and throat (external provider). Only low risk patients have operations on this site as there are no support services.

There is a dedicated surgical ward, day surgery unit and pre-assessment unit which undertakes pre-assessment for both Queen Mary's hospital and Darent Valley hospital.

We inspected the surgical admission lounge, theatre suite and Avery Hill Ward at Queen Mary's hospital.

The trust had 22,165 surgical admissions between July 2016 and June 2017. Emergency admissions accounted for 5,180 (23%), 12,036 (54%) were day case, and the remaining 4,949 (22%) were elective.

## Summary of this service

We rated it as good because:

- Staffing on the day of our inspection was sufficient to meet the needs of the patients.
- Patients and relatives told us they felt involved in decisions about their or their loved-ones care and treatment.
- The service contributed to the national joint register for joint replacement surgery.
- There was good multidisciplinary working within different speciality surgery services. Access to the multidisciplinary workforce was sufficient to meet the needs of patients.
- All staff had received annual appraisals.
- Patient's pain was assessed and managed effectively. There was access to anaesthetists who provided support regrading pain management.
- We saw staff were caring and compassionate to patients' needs.
- There was evidence of learning from incidents and staff said they received feedback regarding incidents.
- There were effective infection control and prevention practices in place. We observed good adherence to trust infection control policies and national guidance.
- Records were complete, well managed and stored securely.
- Patient feedback was continually positive about staff and the care they received. Patients we spoke to had undergone treatment on multiple occasions at the hospital and were overwhelmingly positive about the care they received.

However:

- The World Health Organisation safer surgery checklist were not consistently used effectively. Despite a never event we found nine out of 10 World Health Organisation safer surgery checklists were incomplete.

# Surgery

- There was not a process which ensured ad-hoc agency theatre staff had the skills knowledge and qualifications to perform their role. When agency staff were requested at short notice managers did not have assurance that they had all the correct pre-employment checks undertaken, were qualified and had the skills and knowledge required to perform their role.
- Safety checks on anaesthetic machines were inconsistently undertaken.
- Patients' confidentiality, dignity and respect was not maintained within the theatre holding bay.
- Compliance mental capacity act training was poor. This meant staff may not have awareness if patients lacked mental capacity to make decisions; or understand best interests decisions or awareness of the Mental Capacity Act 2005.
- There were not established procedures and practices in place for invasive procedures.

## Is the service safe?

**Requires improvement** 

We rated it as requires improvement because:

- The World Health Organisation safer surgery checklist were not consistently used effectively. Despite a never event at the hospital we saw completion of the World Health Organisation safer surgery checklist was poor. We reviewed 10 checklists and nine had incomplete information.
- The World Health Organisation safer surgery checklist appeared on the surgery risk register multiple times. However, we observed poor compliance which meant there was a lack of oversight and monitoring.
- Anaesthetic machine safety checks were not undertaken consistently in line with national guidance.
- We found medicines on the resuscitation trolley on the day surgery unit had expired. This was despite a recent check which confirmed all items were within date and safe to use. This meant the process for checking the equipment was not effective.

However:

- Mandatory training compliance was generally good. Staff reported accessing mandatory training was easy and met their training needs.
- Patients were monitored in order to identify any deterioration. Patient records and audit findings showed patients were monitored regularly and action taken if required
- Staff were able to give examples of learning from incidents and said they received feedback from incidents.
- There were effective infection control and prevention practices in place. We observed staff followed trust policies and national guidance to minimise the spread of infection.
- Records were complete, well managed and stored securely.
- Patients were effectively pre-assessed to ensure their needs could be met at the hospital.

## Is the service effective?

**Good** 

# Surgery

We rated it as good because:

- Staff obtained and recorded consent in line with relevant guidance and legislation.
- Care reflected evidence based practice and national guidelines. For example, staff followed the National Institute for Health and Care Excellence guidance on preparing and prevention of surgical site infection prior to surgery.
- The service contributed to national clinical audits. In 2015/16 the proportion of patients undergoing surgery for groin hernias at the trust that reported an improvement was lower than the England average. However the proportion of patients that reported a worsening of their condition was slightly lower than the England average. Data was not supplied by hospital only trust wide.
- All staff had received an annual appraisal.
- Patients' pain was well managed .Anaesthetists were available to provide support in the management of pain.
- There was good multidisciplinary working within different specialities. There was adequate support from specialist teams.
- There were no new pressure ulcers, falls with harm or new catheter urinary tract infections between September 2016 and September 2017 for Surgery at Queen Mary's hospital.

However:

- There was not a process which ensured ad-hoc theatre agency staff had the necessary skills, competence and qualifications to perform their role to perform their role. When agency staff were requested at short notice managers did not have assurance that they had all the correct pre-employments checks undertaken, were qualified and had the skills and knowledge required to perform their role.
- Compliance with mental capacity act training amongst nursing staff was poor. This meant staff may not have awareness if patients lacked mental capacity to make decisions; or understand best interests decisions or awareness of the Mental Capacity Act 2005.

## Is the service caring?

**Good** ●

We rated caring as good because:

- Patients and relatives told us they felt involved in decisions about their or their loved ones care and treatment.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The trust had a range of methods they used to manage patients with extra needs such as mental health issues, learning disability, autism or dementia.
- The service helped people and those close to them cope emotionally with their care and treatment.

## Is the service responsive?

**Good** ●

This is the first inspection of these services. We rated it require good because:

# Surgery

- We found reasonable adjustments were made to take into account the needs of different people for example on the grounds of religion, gender disability, or preference.
- The trust had good support arrangements for those with additional needs. These were identified at pre-assessment to ensure their needs could be met. Staff could access the learning difficulty and dementia team's at Darent Valley hospital to provide additional support for patients if required.
- The needs of the local population were fully identified, understood and taken into account when planning services. Pre-admissions was responsive to the needs of patients and flexible in the way it ran the service Pre-assessment investigations and appointments could be undertaken at a number of different locations to suit patients circumstances.
- Services were constantly reviewed and expanded to meet the needs of the local population.
- Operating lists were undertaken at the weekend if additional capacity was required to meet demand of the service.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Between July 2016 and June 2017, the average length of stay for all elective patients at Queen Mary's hospital was lower than the England average. For example, the average length of stay for elective orthopaedic patients was 2.3 days, which was lower compared to the England average of 3.4 days.
- Between September 2016 and August 2017 the trust's referral to treatment time for admitted pathways for surgery was similar to the England average and followed this trend over time. In the latest period, August 2017 92% was achieved.

However:

- The theatre holding bay did not maintain patient confidentiality, dignity or respect due to its design.

## Is the service well-led?

**Good** 

We rated it as good because:

- Staff felt actively engaged and empowered. There was a good culture among staff and they enjoyed their work.
- All nursing staff spoke enthusiastically of the managers and they felt supported. Staff told us that the managers undertook daily ward and department visits.
- Surgical services had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers encouraged staff to develop and ensured they had access to further training and development opportunities.
- Candour, openness, honesty and transparency were evident throughout the service.
- There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. Relevant risks were highlighted on the hospital risk register and mitigations in place to reduce the risk. For example the risk of needing to transfer patients to another hospital if their health deteriorated was highlighted on the risk register. An action to mitigate the risk was all nurses were undertaking a 'transfer' course. This ensured they had the skills and knowledge when required to transfer a patient to Darent Valley hospital.

# Surgery

- All risks entered on the surgical service risk register that were specific to Queen Mary's hospital had been reviewed within the last 12 months.
- Managers and staff were committed to expanding and developing services provided. Managers ensured any changes to services provided were effectively risk assessed.
- Managers were receptive to the concerns we raised and took immediate action to address these. For example, managers ensured changes were made immediately to the World Health Organisation safer surgery checklist to ensure they were completed correctly.

However:

- Managers did not have oversight which ensured ad-hoc agency staff had the correct skills knowledge and qualifications to perform their role in theatres.
- Despite a never event there was poor compliance with the World Health Organisation safer surgery checklist.
- There were not established procedures and practices in place for invasive procedures.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Darent Valley Hospital

Darent Valley Hospital  
Darent Wood Road  
Dartford  
Kent  
DA2 8DA  
Tel: 01322428100  
[www.dvh.nhs.uk](http://www.dvh.nhs.uk)

## Key facts and figures

Darent Valley Hospital is a modern general hospital located in north Kent providing an extensive range of acute services, mainly hospital based. The hospital provides specialty services including, day-care surgery, general surgery, trauma, orthopaedics, and cardiology, maternity and general medicine.

There are currently 463 beds. The hospital provides services to approximately 350,000 people per annum.

## Summary of services at Darent Valley Hospital

**Requires improvement** ● → ←

Our rating of this hospital stayed the same. We rated it as requires improvement.

# Urgent and emergency services

Requires improvement   

## Key facts and figures

The emergency department saw 100,455 attendances in 2016/17. There are nine minors' cubicles and 20 majors' cubicles. One can be flexed into a rapid assessment and treatment cubicle or majors step-down area (by providing additional chairs). The resuscitation area has four bays which can stretch to five. There are approximately 120 doctors, nurses and other practitioners.

Walk-in patients are streamed by an advanced nurse practitioners between 08.00-20.00 Monday to Friday. There was an on-site General Practitioner from 10.00-23.00 daily for re-directing non-acute patients.

There was a rapid assessment and treatment multidisciplinary team (running for up to 13 hours per day) led by a Consultant or middle grade doctor and assisted by a junior doctor (Foundation Year 2), nurse and emergency department assistant.

The acute medical unit has 31 beds with consultant decision making coverage for 14 hours Monday to Friday and 12 hours at weekends. The acute medical unit works closely with ambulatory emergency care unit to provide pathway based ambulatory care, seeing around 50% of referrals to acute medicine managed and discharged home same day.

The Clinical Decisions Unit has 4 non-ambulant bays (beds) and 8 ambulant bays (chairs) in use under strict protocols, and managed under the care of the Emergency Department medical team.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff were not meeting the trust mandatory training targets.
- Safeguarding processes were not effective at ensuring patients were protected from the risk of abuse.
- Poor infection control standards went unaddressed.
- There was a lack of robust audit to monitor and improve care quality.
- Managing flow throughout the hospital presented as a challenge. This had a significant impact on the department's ability to care for patients during busy times and to meet its national targets.
- The systems and processes to learn from incidents and complaints were not embedded and therefore not being used to prevent recurrence or improve the service.
- The chair patients on Cypress ward shared mix sex accommodation. At busy times, this area lacked space which meant patients dignity and confidentiality was not maintained.
- There was a lack of nurse leadership and oversight in the department. A general manager and deputy had the leadership responsibility for urgent and emergency care and medicine. We considered the current structure and managerial approach to unsustainable, a risk to the organisation and staff personal wellbeing.
- We were not assured the governance and risk management systems were effective.
- Medical records were not stored securely.
- Staff morale was low.

# Urgent and emergency services

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- We found a lack of robust systems and processes to protect adults and children from the risk of abuse.
- Mandatory training compliance was below the trust recommended bench mark.
- Systems and processes regarding the oversight of temporary workers required development required further development to ensure compliance with the Health and Social Care Act 2008 regulations.
- Patients were not protected from the risk of acquiring healthcare acquired infections. The service did not always act to address poor infection control performance which meant that patients were not protected from the risk of healthcare acquired infections.
- The department was failing to meet the Royal College of Emergency Medicine guidelines on consultant cover.
- The standard of records lack consistency and varied greatly across the department. Records were not stored in line with regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The systems and processes used to manage patient safety incidents were not effective because there was a lack of learning to prevent recurrence.

However:

- The service had generally suitable premises with the exception of Cypress ward. Equipment was well maintained in line with trust guidelines.
- Staffing in the department met the recently reviewed establishment. However, increased demand and the recent service reconfiguration would put the lean staffing numbers under significant pressure.
- The service prescribed, gave, recorded and stored medicines well. Patients mostly received the right medication at the right dose, at the right time.

## Is the service effective?

**Requires improvement** ●

We have not rated effective before. We rated it as requires improvement because:

- There was a lack of local audit to monitor quality and improve services.
- Data from the Royal College of Emergency Medicine national audits programme demonstrated variable performance. For example, but not limited to sepsis, pain, severe asthma, cognitive impairment in older people audits.
- Mental Capacity and Deprivation of liberty safeguards were not widely understood by staff.
- Between August 2016 and July 2017, the trust reported 1,082 “black breaches”. The highest numbers of breaches were reported in December 2016 (194) and January 2017 (249). A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

However:

# Urgent and emergency services

- The service provided care and treatment based on national guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Patients told inspectors their pain needs were met whilst in the department.
- The service monitored the effectiveness of care and treatment by partaking in national audit activity. The findings were used to improve the service.
- Staff had the necessary skills to meet peoples individual care needs.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well, and with kindness.
- We saw staff treat patients with dignity and respect during the inspection.
- Patients told us they received care that met their individual needs, and respected their wishes.
- Staff provided emotional support to patients to minimise their distress.
- Patients and those close to them were involved in making decisions about their care and treatment.

However:

- It is worth noting that there was a theme identified in the department which indicated concerns with staff attitude.

## Is the service responsive?

**Requires improvement** ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Access and flow throughout the hospital presented a challenge to the department. This meant that patients experienced delays in care, and the department struggled to meet its national targets. In particular, this related to moving patients from the urgent and emergency care to other departments in the hospital.
- There was a concerning disconnect between urgent care and other hospital departments. This was exacerbated by silo working, and was responsible the feeling in the department that managing the hospital front door, and patient flow, was exclusively an 'A&E problem'.
- For example, patients with cognitive impairment, lack of handovers and mixed sex breaches in the seated area of Cypress ward, and booking in process in main reception area.
- We were not assured the systems and processes to learn and improve from complaints was effective.

However:

- The trust planned and provided services in a way that met the needs of local people.
- The service made adjustments for patients' religious, cultural and other preferences.

# Urgent and emergency services

- The department had changed the patient flow two weeks before the inspection. Whilst the initial data looked like the changes were having a positive effect on the performance metrics, it was too early to comment on the overall effectiveness of these changes as they were not fully embedded in practice.

## Is the service well-led?

**Requires improvement** ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Leadership and oversight in the department required development. There were competent leaders in place, however, their very broad portfolios, which along with a lack of senior nursing leadership meant capacity was limited.
- Whilst there was consistent input and visibility from some senior managers, staff felt the visibility was not equitable.
- We were not assured that there were effective governance systems and processes in place. There was little focus on the management of risk. There was little learning and oversight to drive standards forward.
- Records were not held in line with regulation 17 of the Health and Social Care Act 2008, or the Data Protection Act 1998.
- Staff morale was low.

However:

- There was a suitable vision and strategy within the Urgent Care department.
- Staff were aware of the vision and strategy and were committed to its implementation.
- Staff demonstrated a commitment to team working and supported each other.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Medical care (including older people's care)

Requires improvement  

## Key facts and figures

The Adult Medicine Directorate includes: respiratory, neurology, ageing and health, diabetic, stroke and dementia services, ambulatory care, general medicine, rehabilitation, nephrology, endoscopy and gastroenterology.

The Ageing and Health Department is currently responsible for inpatients on Spruce, Ebony, Linden, Maple (orthogeriatric and medical outliers), medical outliers on Mulberry, Cherry and Rosewood wards.

Stroke services include thrombolysis, acute care and rehabilitation. There is a Monday to Friday Transient Ischaemic Attack clinic with Doppler and Magnetic Resonance Imaging. The service is waiting for the outcome of the Kent-wide Stroke Services Review. The endoscopy service is Joint Advisory Group on Gastrointestinal Endoscopy accredited with inpatient and outpatient slots.

The trust had 31,991 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 11,835 (37%), 5,994 (19%) were elective, and the remaining 14,162 (44%) were day case.

Admissions for the top two medical specialties were:

General Medicine 11,496

Gastroenterology 5,718

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Staff did not have the required level of safeguarding training.
- We saw poor adherence to infection control policies and these were not correctly monitored for compliance. Audit results were not consistent with what we witnessed on inspection. Wards were not always clean and infection prevention methods were not consistently used.
- Maintenance of equipment was not in-line with trust policy or national guidance. We saw equipment that was not well maintained and not consistently cleaned to ensure the spread of infection was minimised.
- Staffing was not always consistent, to allow for continuity of care and seven day working.
- The use of escalation beds meant patients were sometimes cared for in beds that were not suitable, for example had no lighting and doorbells were used in place of call bells.
- We saw wards still had mixed sex bays or shared toilet and shower facilities. This was a breach of our regulations and staff did not demonstrate an understanding of this regulation.
- There was no clear vision and not all staff were aware of the departmental changes going forward.
- We saw several breaches of confidential patient information across the department. This included patient information left displayed on screens and discussions about patients held in open areas.

However:

- We saw good multidisciplinary working and patient focused staff. The needs of patients were considered at all stages of their treatment, both physically and psychologically.

# Medical care (including older people's care)

- Patients who required extra assistance or had specific needs had these met wherever possible.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Mandatory training figures were not in-line with trust targets. Staff did not have the required level of safeguarding training, particularly children's safeguarding. Figures for level one and two children's safeguarding training were much worse than trust targets.
- We saw some poor compliance with infection control policies throughout the hospital. The service did not always control infection risk well and found areas of the hospital that were not clean.
- We saw some poor management of medical equipment. Monitoring whether safety systems were implemented was not robust and we had concerns about the consistency of staff awareness and understanding of them.
- Patient confidentiality was not always maintained as we witnessed patient identifiable information on unattended computer screens. We also saw discussions about patients' treatment held in open areas where members of the public and hospital staff could overhear.
- Although we saw the service prescribed, gave and recorded medicines well, we found that medicines were not consistently stored securely to minimise unauthorised access.
- It was not clear how the service was using safety monitoring results to improve the service.

However:

- Staff kept contemporaneous records of patients' care and treatment. Records were clear, up-to date and available to all staff providing care.
- Overall, there was sufficient medical staff with required skill mix to meet the needs of the patients on a day-to-day basis. Agency staff were used to fill shifts regularly and we witnessed some issues relating to training and competencies. However, the trust had taken measures to address staffing issues and there were ongoing measures to further improve staffing levels.
- Risk assessments were carried out using the National Early Warning Score upon and throughout the admission. This ensured patients were identified early should their condition have deteriorated.

## Is the service effective?

**Requires improvement** ● ↓

Our rating of effective went down. We rated it as requires improvement because:

- Consultants did not always work in a shift pattern that promoted continuity of care. This had led to delayed discharges and patients being reviewed twice unnecessarily.
- The stroke ward (spruce) did not have seven day working. The trust has seen a decline in the Sentinel Stroke National Audit Programme audit with domain 2: overall team-centred rating score for key stroke indicator worsening from level C in April to June 2015 to level E in April to July 2016. Although at the time of inspection this had increased to D the ward still performed much worse in comparison to the national average.

# Medical care (including older people's care)

- The National Diabetes Inpatient Audit had not shown improvement from the previous year. Both 2016 and 2017 results placed them in the bottom 25% of trusts.
- Staff competencies were not routinely checked.
- The directorate did not routinely undertake clinical supervision to ensure staff competencies were up to date.
- Not all services were available seven days a week, for example the stroke services and dialysis unit.

However:

- We saw patients with complex needs received prompt screening by a multi-disciplinary team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multidisciplinary assessment was undertaken and care plans were put in place from admission.
- Staff we spoke with had good awareness of what to do if patients lacked the mental capacity to make decisions; they understood best interest decisions and showed good awareness of the Mental Capacity Act 2005.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff understood and respected the personal, cultural, social and religious needs of patients; we witnessed these being discussed in relation to their care needs.
- Staff showed they understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them.
- Staff provided emotional support to patients to minimise their distress. Family members and carers were involved in all discussions around a patient's care.
- We saw genuine and caring interactions from staff across the department, often patients referred to staff by their first names showing they were familiar with them.

However:

- Although we saw several instances where patients' dignity and privacy had been respected, we also witnessed a staff member too busy to notice two patients who were not sufficiently covered in the Acute Medical Unit.
- We also witnessed a healthcare assistant who was impatient with a patient who was hard of hearing. Although all other interactions we witnessed throughout the inspection were kind and caring.

## Is the service responsive?

**Requires improvement** ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The hospital did not always consider people's individual needs within the department. During our previous inspection in 2013 we found that there were mixed gender bays in use. We found that during our recent inspection there were still mixed gender breaches and bays in use. Staff reported it was a daily occurrence and were unable to fully explain the reasons for the breaches. We also found they did not have a full understanding of the regulation.

# Medical care (including older people's care)

- There was a notable increase in medical outliers in medical care. Medical outliers are patients placed in other departments' wards (usually surgical wards) due to the lack of beds in medical wards.
- During our comprehensive inspection in 2013 the trust were told they must ensure that at all times patients are cared for in a safe environment that is designed to meet their needs. We still saw 'escalation' beds in use on Chestnut ward, Linden ward and AMU. The beds on Chestnut ward in particular are not fit for purpose and have no lighting, piped oxygen and are using doorbells to attract the nurse's attention if needed.

However:

- Board rounds were effective and managed the flow of patients coming in and out of the hospital by identifying those patients that were ready for discharge in a timely manner.
- We saw that services were delivered in a way that focused on people's needs and individual preferences.
- The average length of stay for medical elective patients at Darent Valley Hospital was 0.5 days, which was better than the England average of 4.2 days.

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- The trust were told to improve on aspects of the medical care service they delivered during our previous inspection in 2013. These had not always been addressed and showed a lack of commitment by the leadership team to implement the recommendations. Examples included mix sex breaches, poor information governance and the use of inappropriate escalation beds.
- The hospital had recently implemented a new model of care that brought the emergency care directorate and adult medicine into one directorate. This included all staff under one umbrella. Less senior staff we spoke with were unclear of the new structure and showed limited knowledge of the impact it would have on the department.
- Apart from the senior staff there was not a clear vision and a set of values that staff recognised. We saw posters with the values displayed on wards, but staff could not repeat these to us and did not have a clear idea of any departmental plans for the future.
- Although there were effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services, these were not effectively reviewed to ensure safe practice, for example cleaning audits were not consistent with what we saw on inspection.
- During our inspection in 2013 we saw occasions when patients' privacy and confidentiality were not always respected, with personal and confidential information on display. This had still not been addressed. During our recent inspection we saw several breaches of patient confidentiality. Staff did not ensure that confidential information was not seen or overheard by others.

However:

- We saw supportive interactions from staff throughout our inspection. Several staff from many different areas reported feeling proud to work for the organisation.
- The trust had recently launched a nurse-led bleep filtering (111) to support junior doctors' workload and streamline clinical resources to demand. It enabled triaging of bleeps and helped to ensure the most urgent patients got seen first.

# Medical care (including older people's care)

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Surgery

Requires improvement   

## Key facts and figures

Surgical services at Darent Valley hospital provide emergency, elective and non-elective day stay and inpatient care. The specialities covered are general surgery, colorectal, upper gastrointestinal surgery, urology, orthopaedic, trauma, gynaecology and ear, nose and throat (external provider).

There are dedicated surgical wards at the acute trust site. The trust has created a separate elective surgical unit at Queen Mary's hospital to manage low risk patients for elective surgery.

The trust had 22,165 surgical admissions between July 2016 and June 2017. Emergency admissions accounted for 5,180 (23%), 12,036 (54%) were day case, and the remaining 4,949 (22%) were elective.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not have the correct level of child safeguarding training, which ensured people were protected from the risk of abuse.
- Compliance with mental capacity act training was poor amongst nursing staff. This meant they nursing staff may not be able to recognise patients or care for patients who lacked capacity.
- Staff do not recognise incidents or near misses and did not always have time to complete incident forms.
- There was evidence of learning from never events however, there was little evidence of learning from other incidents or action taken to improve safety.
- Patients dignity, respect and confidentiality was not maintained in theatres.
- Staff did not assess, monitor or manage risks to patients who use their services. Records showed that patient associated risks were not consistently assessed.
- Infection control practices were not effective and hand hygiene practices in the recovery unit placed an unacceptable risk to patient safety. Audit results were not consistent with what we observed during our inspection.
- There were not systems in place to ensure that emergency equipment was available and safe to use.
- Substances that could cause harm were not stored securely in ward areas. This meant unauthorised personnel could gain access to them.
- The delivery of high quality care was not assured by the leadership, governance or culture in place.
- Care and treatment was not prioritised in line with national guidance. Emergency operations were not categorised in accordance with national guidance which placed patients at an increased risk.
- Patient records were incomplete, poorly managed and not stored securely on ward areas. This meant patient confidentiality was not maintained and in an emergency it may be difficult to obtain essential information about the patient.
- There was a failure to act upon identified risks. The lack of correct child safeguarding training, lack of paediatric life support training and unsafe medical cylinder storage had been previously identified as risks.

# Surgery

- Staff in theatres did not have the required knowledge, training and skills to care for children. Staff had not received paediatric life support training despite regularly caring for children in recovery units.
- There was not a process which ensured staff had the necessary skills and competence to perform their role within theatres. Staff completed a competency documents when they first started in the department but there was not a process for reviewing staff competence.
- Staff, relatives and the internet were used to interpret for patients who did not speak English. This was not considered to be best practice.
- There were not established procedures and practices in place for invasive procedures.

However:

- During our inspection and review of records staffing was sufficient to meet the needs of the patients.
- Patients and relatives told us they felt involved in decisions about their or their loved-ones care and treatment.
- The service contributed to national clinical audits for surgery. For example the national laparotomy audit ,national joint register and the national hip fracture database.
- There was good multidisciplinary working within different speciality surgery services. We observed and saw evidence of multidisciplinary input into patient care.
- All staff had received annual appraisals.
- Patients pain was managed effectively, staff and patients said there was good support from the acute pain service.
- We observed that staff were caring and compassionate to patients' individual needs.

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- Staff did not have the correct level of safeguarding training, which ensured people were protected from the risk of abuse.
- Staff did not recognise incidents or near misses and did not always have time to complete incident forms. This meant learning from incidents was limited and incidents may have gone unreported .In addition, staff were unable to give us examples of learning from incidents or any feedback from incidents.
- There was evidence of learning from never events. We observed the changes that had been made following the never events. This meant action had been taken to minimise a reoccurrence. However, staff did know how to report incidents.
- We saw there was learning from serious incidents, we reviewed root cause analysis which showed they were thoroughly investigated.
- Staff did not assess, monitor or manage risks to patients who use their services. The use of patient risk assessments such as pressure ulcer and venous thromboembolism assessments was inconsistent. This meant patient risk was not understood and actions to mitigate risks taken.
- Infection control practices were not effective and hand hygiene practices, placed an unacceptable risk to patient safety. Hand hygiene audit results were not consistent with what we observed during our inspection.

# Surgery

- There were not systems in place to ensure the availability and safety of equipment in theatres. The checking of equipment was not in-line with trust policy or national guidance.
- Substances that could cause harm were not stored securely. This meant unauthorised personnel could gain access to them.
- Patient records were incomplete, poorly managed and not stored securely. This meant patient confidentiality was not maintained and in an emergency essential patient information was not easily accessible.
- There was a failure to act upon identified risks. The lack of correct child safeguarding training, lack of paediatric life support training and unsafe medical cylinder storage had been previously identified as risks.
- Care and treatment was not prioritised in line with national guidance. Emergency operations were not categorised in accordance with national guidance which placed patients at an increased risk.
- Fire safety measures were not adequate. Fire prevention strips fitted to a door within the day surgery unit were faulty and would not provide protection in the event of a fire.

However:

- Medicine management processes were effective. We saw the service prescribed, gave and recorded medicines and stored in line with trust policy well.
- Mandatory training compliance was generally good.
- Patients were monitored in order to identify any deterioration. Patient records and audit findings showed patients were monitored regularly and action taken if required.
- The World Health Organisation safer surgery checklist was consistently, effectively and reflected recent changes from the never events.

## Is the service effective?

**Requires improvement** ● ↓

Our rating of effective went down. We rated it as requires improvement because:

- Staff in theatres did not have the required knowledge, training and skills to care for children. This was because staff had not received any life support training for children.
- There was not a process which ensured staff had the necessary skills and competence to perform their role within theatres. Ongoing competence was not reviewed and therefore not assured.
- The service contributed to national clinical audits. In 2015/16 the proportion of patients undergoing surgery for groin hernias at the trust that reported an improvement that was lower than the England average. However the proportion of patients that reported a worsening of their condition was slightly lower than the England average. Data was not provided by hospital site only trust wide.
- Performance in the national hip fracture audit was varied, 30 day mortality was within the expected range, percentage of patients having surgery on the day of or day after admission was within the expected standard. The percentage of patients undergoing a perioperative medical assessment did not meet the standard.

# Surgery

- In the 2016 Bowel Cancer Audit, 81% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate of 69%. The risk-adjusted 90-day post-operative mortality rate was within expected range. The risk-adjusted two-year post-operative mortality rate was worse than expected. The risk-adjusted 30-day unplanned readmission rate was within expected range. The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was within expected range.
- Compliance with Mental Capacity Act training was poor. This meant staff may not have awareness if patients lacked mental capacity to make decisions; or understand best interest decisions or awareness of the Mental Capacity Act 2005.
- Patients were not reviewed by consultant within the 14 hour standard out of hours. The Royal College of Physicians' Acute Care Toolkit four suggests that all patients admitted in an emergency should be seen promptly by a suitable consultant and at the latest within 14 hours of admission. This meant there may be a delay to patients receiving the correct care and treatment.

However:

- Staff obtained and recorded consent in line with relevant guidance and legislation.
- We observed care reflected evidence based practice and national guidelines and this was confirmed within patient records.
- The service contributed to national clinical audits. These included the national laparotomy audit, national joint register and the national hip fracture database.
- Most staff had received an annual appraisal.
- Patients' pain was well managed and there was good support from the acute pain team.
- There was good multidisciplinary working within different specialities .We observed good multidisciplinary working and we saw evidence of multidisciplinary input within the patient records.

## Is the service caring?

**Good** ● ↑

Our rating of caring improved. We rated it as good because:

- Patients and relatives told us they felt involved in decisions about their or their loved ones care and treatment.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The trust had a range of methods they used to manage patients with extra needs such as mental health issues, learning disability, autism or dementia.
- The service helped people and those close to them cope emotionally with their care and treatment.

However:

- Patients dignity, respect and confidentiality was not maintained in theatres, whilst waiting for their operations.

# Surgery

## Is the service responsive?

**Requires improvement** ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The systems and processes to learn and improve from complaints were not effective. Complaints were not routinely discussed at department or ward meetings and were not a standard agenda item.
- Relatives, staff and the internet were used to translate for patients who did not speak English. The use of family, friends or unqualified interpreters is strongly discouraged in national and international guidance and is not considered good practice. The trust had translation services available however staff said they avoided using them when they could to reduce cost.
- The average length of stay for all non-elective patients at Darent Valley hospital was 6.5 days, which was higher compared to the England average of 5.1 days. The average length of stay for non-elective urology, trauma and orthopaedic and general surgery patients was high compared to the England average. For example, the average length of stay for trauma and orthopaedics patients at Darent Valley Hospital was 10.4 days, which was higher compared to the England average of 8.9 days.
- Length of stay for elective general surgery was lower than the England average and average length of stay for urology and trauma and orthopaedic patients was within the expected range.
- Between September 2016 and August 2017 the trusts referral to treatment time for admitted pathways for surgery was worse than the England average and had followed a similar trend over time. In the latest period, August 2017 60% of this group of patients were treated within 18 weeks versus the England average of 70%. The worst speciality was urology with 67% of patients had a referral to treatment time of 18 weeks compared to the England average of 77%.
- In main theatres, we saw patients waited for surgery in a bay located closely together and patients were mixed sexes. This meant patients individual needs were not considered whilst in the department.
- The environment was not always well maintained and suitable to meet the needs of patients. In the day surgery unit we saw equipment in corridors and the main corridor was used to recover patients it was chaotic and disorganised. This environment could be especially confusing or distressing for patients with dementia or additional needs.

However:

- The service effectively managed the availability of surgical beds. There was minimal medical outliers in surgical wards.
- We found reasonable adjustments were made to take into account the needs of different people for example on the grounds of religion, gender disability, or preference.
- The trust had good support arrangements for those with additional needs. We observed that services were delivered in a way that focused on people's individual preferences and needs.
- Between September 2016 and August 2017 the Trust's referral to treatment time for admitted incomplete pathways for surgery was similar to the England average and followed this trend over time. In the latest period, August 2017 92% was achieved.

# Surgery

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- The delivery of high quality care was not assured by the leadership, governance or culture in place. For example, there was a lack of management oversight and accountability for the day surgery unit. Therefore there was no management oversight or management of risk within the department and the governance framework in place was ineffective.
- There was not a vision and strategy for the surgery service.
- There was a disconnect between main theatre, the day surgery unit at Darent Valley Hospital and Queen Mary's hospital. Processes were not mirrored across the different departments and hospital sites. Main theatres and the day surgery unit worked in silos at Darent Valley hospital.
- We were not assured mortality and morbidity was effectively reviewed across all surgical specialities. We were only assured that these were occurring within the orthopaedic speciality.
- Managers failed to identify risks or take action on identified risks. Managers were not aware of poor practice and non-adherence to trust policy and national guidelines. For example, a manager was aware of non-compliance with regard to national guidance and the management of emergency surgery but had failed to identify this as a risk and take action.
- There was a lack of quality assurance processes in place within theatres. For example, there was a lack of monitoring that equipment safety checks were undertaken.
- There was an over reliance on audit findings as assurance of good practice. For example, hand hygiene audits in recovery did not reflect what we observed during the inspection.
- There were not established procedures and practices in place for invasive procedures.
- Department and ward meetings were not effective. Meeting agendas did not follow a set format which included discussion of complaints and incidents. This meant key learning messages were not reaching staff at ward or department level.

However:

- Staff demonstrated a commitment to team working and supported each other.
- Staff morale was generally good and staff showed a strong commitment to the organisation.
- Staff felt supported by junior sisters, ward managers and matrons. Staff reported feeling valued.
- We observed practices had been changed as a result of never events. We saw never events had undergone a thorough investigation and lessons learnt highlighted.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Maternity

Good   

## Key facts and figures

We last inspected Dartford and Gravesham NHS Trust maternity services in December 2013. We found the service good overall. The purpose of this inspection was to see if the services performance had been maintained or if any improvements had been made by the service in the interim. Dartford and Gravesham National Health Service trust maternity services are delivered at Darent Valley hospital. Between January 2016 and June 2017 the bed occupancy levels for maternity at Darent Valley hospital were generally higher than the England average, with the trust having the highest levels of bed occupancy in quarter one 2017/18 ~90%, compared to the England average of 60%.

### Summary of this service

Our rating of this service stayed the same. We rated it as good because.

- Overall, medicines were managed. The pharmacist visited daily and checked drugs and administration charts.
- Incidents were discussed at handovers and morning meetings.
- All staff we spoke to were aware of their responsibilities relating to Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014.
- Overall, care was being provided in line with the National Institute for Health and Care Excellence quality standards. We saw evidence that all guidance and policies within maternity services had been reviewed and were based upon current guidance.
- The trust had achieved level three United Nations Children's Fund Baby Friendly accreditation in January 2018. The Baby Friendly Initiative is based on a global accreditation programme of United Nations Children's Fund and the World Health Organisation.
- The maternity services key performance indicator dashboard recorded the service were consistently better than the trust's target rate of 5% for third and fourth degree perineal tears during labour. (A perineal tear is a laceration of the skin and other soft tissue structures that, in women, separate the vagina from the anus).
- Between April 2016 and March 2017, the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections were as expected.
- There were comprehensive training and education opportunities available to staff. The trust employed two dedicated maternity education lead midwives. New midwives joining the trust completed a comprehensive preceptorship programme.
- All supervisors of midwives were transferring to the professional maternity advocate role. Professional maternity advocates are experienced practising midwives trained to support and guide midwives to deliver care developed nationally and locally.
- The October 2017 maternity newsletter informed staff of a new pathway for the mother and infant mental health service and gave staff guidance on how to refer to the service. Maternity services had recently been allocated a consultant psychiatrist for one day a week. The service also had a lead mental health midwife.
- There had been no maternity unit closures between September 2016 and October 2017.
- Complaints were responded to and closed in less than 25 workdays.

# Maternity

- The antenatal unit was midwife led. Staff were committed to providing and promoting normal birth. Most women we spoke with told us they felt involved in planning and making decisions about their care.
- We found a positive culture in maternity services. Staff reported that they felt supported by their immediate line management and that they had good working relationships with other specialties in the hospital.
- Maternity had a dashboard that was used to monitor key performance indicators. The service's strategic goals were monitored via the clinical solutions meeting. The meeting looked at maternity key performance indicators' and decided strategy to meet or improve the Key Performance Indicators.
- The maternity service had completed actions to meet the requirements of the 'saving babies lives' care bundle, with the aim of reducing stillbirths, neonatal deaths, and intrapartum brain injuries.

However:

- The maternity education department specific database was not aligned to the trust's mandatory training spreadsheet.
- The 'strategic and operational cleaning plan' was out of date and overdue for review.
- There was a lack of obstetric theatre nurses and operating department practitioners, 24 hours a day seven days a week, to support the anaesthetist if required. The service audited the use of theatre two between February and October 2017. The audit found in theatre two it was predominantly midwives scrubbing (86%), with most of these midwives (77%) coming from the delivery suite. In 23% of cases, midwives had to be utilised from other ward areas.
- The midwife to birth ratio was 1:36, (this means there was 36 births to one midwife), this was identified on the trust's risk register. The risk register acknowledged the midwife to patient ratio was not at the agreed level according to Birthrate Plus. The risk register also recorded that increasing case complexity and a high midwife to birth ratio increased risks to women and babies; the risk register also recorded that only one part time scrub nurse was available on the delivery suite. Following our inspection the trust informed us there were processes in place to mitigate the risk from the midwife to birth staffing ratio.
- In June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average. The proportion of junior, foundation years one and two, staff was higher than the England average.
- A never event involving a retained swab had occurred at the weekend, in October 2016. However, this followed a previous incident involving a retained gauze ball in August 2016 which was downgraded from a never event to serious incident. The service showed us evidence of the learning being communicated to staff following the retained swab event. However, learning from the October 2016 event had not been timely.
- The trust was in the process of moving to electronic records. Staff told us there were issues with records being scanned onto women's electronic health records, and records sometimes went missing for up to two weeks during transit to scanning.
- The risk register did not contain timescales for when identified actions should be completed.

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

# Maternity

- The maternity specific database, which was used by the maternity education department, was not aligned to the trust's mandatory training spreadsheet. Staff said there was a six week delay between staff completing mandatory training and this showing on the trust's mandatory training figures.
- The 'strategic and operational cleaning plan' we received from the trust was out of date and overdue for review.
- We saw rusty drain covers and exposed wood on a bidet on Aspen ward. This posed a risk to infection prevention. We also saw a room with rust around the base of the toilet as well as sealant that was corroded on the shower in the same room. Staff were not aware if these had been reported.
- We were not assured the security of the unit at the main entrance was sufficient.
- There was a lack of obstetric theatre nurses 24 hours a day seven days a week. There was one scrub nurse available on the delivery suite, Monday to Saturday 8am to 6pm. This was on the maternity service risk register.
- The risk register identified that an operating department practitioner outpatients, (these are staff that support operating theatre staff and provide care to women at all stages of an operation), was available, but did not provide 24 hour cover, seven days a week.
- The midwife to birth ratio was 1:36, (this means there was 36 births to one midwife), this was identified on the trust's risk register. The risk register recorded that maternity leave amongst the maternity service staff was high.
- In June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior, foundation years one and two, staff was higher than the England average.
- Consultant presence on the delivery suite was identified on the maternity risk register. Consultant resident hours on the delivery suite were not defined for evening and weekends. Staff told us consultants were not always visible on the labour ward.
- A consultant had recently told the trust they were not intending to return. Staff told us the locum obstetrician covering this post had also taken maternity leave. Staff told us they were advertising the consultant vacancy and filling the vacancy was a trust priority.
- A never event involving a retained swab had occurred at the weekend. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The maternity services never event in October 2016 followed a previous incident in August 2016 which was downgraded from a never event to a Serious Incident. There was evidence of learning being communicated to staff following the serious incident. However, we noted a lack of timely learning from the first incident.
- The trust was in the process of moving to electronic records. Paper based notes were being scanned onto the electronic records system. However, staff told us there were issues with records being scanned onto the electronic records system. Records sometimes went missing for up to two weeks during transit to scanning.
- 

However:

- The service re-audited the use of the 'perineal repair page in women labour' in June 2017. These were tools which recorded post-natal repairs to women's perineum. The audit found 83% compliance with use of the suturing proforma or suturing page in women notes. As a result of the re-audit the service had added an appendix to the trust's 'perineal trauma guideline – intentional vaginal pack retention.' Patients would have a luminous wristband attached for each pack in place. All wristbands were checked against the patient record to minimize the risk of vaginal packs not being removed following suturing.

# Maternity

- Staff completed risk assessments to help women choose their preferred place of delivery.
- Most staff working on maternity wards had undertaken paediatric immediate life support courses and new-born life support courses.
- All women had a named consultant (for high-risk pregnancies) or a named midwife (for low risk pregnancies).
- Incidents were widely reported and openly discussed. Staff discussed incidents at handovers and morning meetings. We also saw staff minuted incidents in ward meetings.
- All staff we spoke to were aware of their responsibilities relating to Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Overall, staff provided care in line with the National Institute for Health and Care Excellence (NICE) quality standard 22. This standard covers the care of all women up to 42 weeks of pregnancy.
- The maternity service used a customised assessment of birthweight and fetal growth via the Gestation Related Optimal Weight programme. This enabled staff to accurately define each pregnancy's growth potential through the use of customised charts. All staff had received training in the use of the Gestation Related Optimal Weight programme charts.
- The trust had achieved level three United Nations Children's Fund Baby Friendly accreditation in January 2018. The Baby Friendly Initiative is based on a global accreditation programme of United Nations Children's Fund and the World Health Organisation. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- The maternity services Key Performance Indicator dashboard recorded the service were consistently better than the trust's target rate of 5% for third and fourth degree perineal tears during labour. A perineal tear is a laceration of the skin and other soft tissue structures which, in women, separate the vagina from the anus.
- In the 2016, National Neonatal Audit programme 100% of babies included in the audit had their temperature measured within an hour of birth; this was above the national average, where 96% of eligible babies had their temperature measured within an hour of birth.
- National Neonatal Audit programme found 70% of babies of less than 33 weeks gestation at birth were receiving mother's milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit; this was above the national average.
- There were comprehensive training and education opportunities available to staff. The trust employed two dedicated maternity education lead midwives. New midwives joining the trust completed a comprehensive preceptorship programme.
- Maternity services had introduced a new model of midwifery supervision. All supervisors of midwives were transferring to the professional maternity advocate role. Professional maternity advocates are experienced practising midwives trained to support and guide midwives to deliver care developed nationally and locally
- Staff demonstrated awareness of what actions to take in the event of a patient lacking the capacity to consent. Staff understood the use of 'Gillick competencies' in relation to children.

# Maternity

However:

- Breastfeeding initiation rates did not meet the trust's targets. The 85% target had not been met between September 2016 and October 2017. The highest rate achieved in this period was 72% in January 2017. The lowest rate was 64% in December 2016. In mitigation the post-natal wards had introduced the '11 o'clock stop' initiative to promote breastfeeding.
- The National Neonatal Audit Programme found 84% of mothers were given a complete or incomplete course of antenatal steroids; this was below the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

## Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good because:

- Between June 2017 and August 2017, the trust's Maternity Friends and Family Test for antenatal birth, postnatal and postnatal community performance was generally similar to the England average.
- The trust performed similar other trusts for 14 out of 16 questions in the Care Quality Commission Maternity survey 2015.
- The antenatal clinic offered an open day in November 2017, offering prospective parents an 'emotional and wellbeing workshop,' as well as practical sessions on parenting.
- Maternity services had recently been allocated a consultant psychiatrist for one day a week. The service also had a lead mental health midwife.
- The antenatal unit was midwife led. Staff were committed to providing and promoting normal birth. Staff offered women a choice of birthing options.
- Most women we spoke with told us they felt involved in planning and making decisions about their care.

## Is the service responsive?

Good  → ←

Our rating of responsive stayed the same. We rated it as good because:

- There were two obstetric theatres within the maternity department which were available 24 hours. Theatre 1 was the main obstetric theatre. Theatre 2 was the emergency obstetric theatre, which was used when theatre 1 was occupied.
- The October 2017 maternity newsletter informed staff of a new pathway for the mother and infant mental health service and gave staff guidance on how to refer to the service.
- There was a bereavement room, 'Serenity,' which was available to parents who had suffered the loss of a baby.
- There had been no maternity unit closures between September 2016 and October 2017. The maternity dashboard recorded two transfers of women 'in utero' outside its network in the same period and no women being transferred within the organisation during this period.

# Maternity

- Women had 24 hour access to the triage phone line for advice or if they were in labour or experienced any immediate problems, such as bleeding.
- The maternity dashboard recorded that between October 2016 and October 2017 an average of 97% of women received one to one care from a midwife during labour. This was slightly worse than, but close to, the trust target of 100%.
- The maternity services annual report 2016 to 2017 reported that 8% of caesarean sections were category 1 emergency, 32% were category 2 urgent, 14% were category 3 scheduled, 46% were category 4 elective.
- Between October 2016 and October 2017, there were 13 complaints to maternity services. All complaints were responded to and closed in less than 25 workdays.

However:

- Between January 2016 and June 2017 the bed occupancy levels for Maternity were generally higher than the England average, with the trust having the highest levels of bed occupancy in quarter one, 2017/18 ~90%, compared to the England average of 60%.
- The service audited the use of theatre two between February and October 2017. The audit found theatre 2 had been open 58 times in the period, with 46 of these being for caesarean sections: 83% of cases were during normal working hours in the week; 10% were out of hours in the evening or at night; 7% were at weekends. In theatre 2 it was predominantly midwives scrubbing (86%), with most of these midwives (77%) coming from the delivery suite. In 23% of cases, midwives had to be utilised from other ward areas. In six out of eight cases this was during normal workday times.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Maternity service had a clearly defined accountability structure. The clinical director told us the trust's medical director was approachable. The clinical director met monthly with the chief executive officer. However, we were told the meeting was not minuted.
- Maternity staff told us the board did 'walk arounds' the hospital and were visible.
- We found a positive culture in maternity services. Staff reported that they felt supported by their immediate line management and that they had good working relationships with other specialties in the hospital. New members of staff said that they were made welcome and everyone was willing to help out.
- There were a range of governance meetings to ensure information flowed from board to ward. For example, the directorate sat within the women and children's directorate. The head of midwifery attended monthly directorate business meetings where finance and performance across the directorate were discussed. Following our inspection the trust informed us that there were regular six monthly workforce committee and board reviews of maternity workforce requirements.
- There were monthly joint maternity and gynaecology risk meetings. Incidents, complaints, and the risk register were regular agenda items the meeting.
- The service's strategic goals were monitored via the clinical solutions meeting. The meeting looked at maternity key performance indicators' and decided strategy to meet or improve performance.

# Maternity

- Maternity had a dashboard which was used to monitor key performance indicators. The dashboard was reviewed at monthly maternity and gynaecology risk governance meetings.
- In response to the National Health Service England 'saving babies lives' (2016) care bundle the maternity service had completed actions to meet the requirements of the 'saving babies lives' care bundle, with the aim of reducing stillbirths, neonatal deaths, and intrapartum brain injuries.
- Staff had the opportunity to provide feedback daily at handover meetings as well as at ward meetings.

However:

- The risk register contained 15 items relating to maternity services. However, these did not contain timescales for when identified actions should be completed.
- An audit of the 30-minute decision to delivery time interval for category 1 caesarean sections between April and September 2017 between April and September 2017 recommended a review of scrub midwife's allocation at time of caesarean sections to determine any impact on patient care. The audit also recommended a review of outpatients' activity at time of caesarean section to determine any impact on patient care. However, obstetric theatre staff told us actions following the recommendations had not been implemented and were unsure about when these would be implemented.
- The staffing ratio was on the trust's risk register. The risk register recorded the trust's intentions were to fund and maintain a retrospective ratio of 1:34 in 2016/17 as defined via safe staffing reviews. Birthrate Plus recommends 1:28 low risk, 1:34 higher risk. The risk register acknowledged the midwife to patient ratio was not at the agreed level according to Birthrate Plus. The risk register highlighted a staffing ratio of 1:36.
- The risk register also recorded that increasing case complexity and a high midwife to birth ratio increased risks to women and babies; the risk register also recorded that only one part time scrub nurse was available on the delivery suite, this posed a risk to the elective list being delayed during the undertaking of unplanned theatre cases

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

#### Regulated activity

#### Regulation

This section is primarily information for the provider

## Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

# Our inspection team

This inspection was led by Vanessa Ward, CQC inspection manager. The team was joined by Catherine Campbell, Head of Hospital Inspection on the well led inspection.

The team included eight inspectors, 17 specialist advisers, and one expert by experience.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.