Care Quality Commission

East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Quality Report

Kennington Road,
Willesborough,
Ashford,
Kent,
TN24 0LZ
Tel: 01233 633331
Website: www.ekhuft.nhs.uk/williamharvey

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The William Harvey Hospital (WHH) in Ashford, Kent is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust (EKUFT).

The William Harvey Hospital (WHH) is an acute 476 bedded hospital providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric and neonatal Intensive care services. The hospital has a specialist cardiology unit undertaking angiography, angioplasty, an analytical robotics laboratory that reports all East Kent's General Practitioner (GP) activity and a robotic pharmacy facility. A single Head and Neck Unit for East Kent has recently been established and includes centralised maxillofacial services with all specialist head and neck cancer surgery co-located on the site.

Following our last inspection of the Trust in March 2014 when we found many of the services the Trust provided to be inadequate, EKUHFT was placed into special measures by the Foundation Trust regulator Monitor. This announced inspection was undertaken to assess what progress the Trust had made in addressing our concerns.

We carried out an announced inspection of EKUHFT between 13- 17 July 2015. We also undertook unannounced visits the following week on 29 July 2015.

At this inspection although we found the hospital overall to require improvement we noted there had been improvements made in the majority of services we inspected, particularly in the emergency department, surgical services, children's services and outpatients.

Our key findings were as follows:

Safe

- At the last inspection we told the Trust they must ensure there were sufficient numbers of suitably qualified, skilled, and experienced staff available to deliver safe patient care in a timely manner. At this inspection we found that although staffing overall had improved through a sustained recruitment initiative and the use of agency and bank staff, recruitment continued to be a problem for the hospital. The numbers, skills and qualifications of staff did not always reflect the needs of patients.
- We continued to have concerns that the environment and facilities in which patients were cared for were not always safe, well maintained, fit for purpose or met with current best practice standards. For example there was only one obstetric theatre, the temperature on the labour ward was excessively high causing mothers and staff to feel ill, in the fracture clinic there was no designated waiting area for children and their families, the waiting room conditions were cramped and overcrowded; there were carpets in clinical areas and we found taps that did not work.
- Access to and availability of equipment had improved since our last inspection through the implementation of an equipment library. However there areas in the hospital where appropriate equipment was not readily available. In the maternity department there was a shortage of basic medical equipment from medical devices such as resuscitation equipment, fetal monitoring equipment and cardiotocography (CTG) devices to broken printers, photocopiers, air-conditioning units and electric fans.
- Although the Trust had revised the adverse incident and serious incident policy and had trained more staff in incident investigation and Root Cause Analysis, patients were not always protected from inappropriate or unsafe care because staff were not always reporting incidents. Where incidents were reported there was good evidence that learning was shared and actions taken to prevent reoccurrence.
- There was evidence of poor record keeping. In the emergency department we saw records that were not held securely. Where daily audits of records were taking place, there had been no action taken to address the shortfalls.

Summary of findings

- The management of medicines did not always meet best practice guidance. We saw medicines not kept secure and fridge and room temperatures not always being recorded. We found a number of patient group directions (PGD's) were out of date.
- Staff were aware of the policies for infection prevention and control and adhered to them. The majority of clinical areas we visited were visibly clean and tidy.
- We found that attendance at mandatory training had improved along with the system for recording and monitoring attendance although the mandatory training targets and agreed actions had not been achieved. Induction was given to all newly recruited nurses and medical staff, including agency nurses.
- Junior doctors told us they felt well supported by the senior medical staff and received regular training.
- The recording of patient assessments and the documentation and monitoring of patients' treatment, needs and observations had improved since our last inspection. Patient observations were undertaken electronically and regular audits were undertaken to check that information was recorded appropriately.

Effective

- Most of the services we inspected provided effective care.
- National guidance was used to inform the care and treatment of patients and services participated in national and local audits.
- Patients generally had good outcomes because they received effective care and treatment that met their needs.
- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- We found there was an effective model of care being used in the emergency department to facilitate prompt treatment of patients on the stroke pathway.
- We spoke with practice development nurses who monitored staff practice and competencies to ensure consistency.
- At the last inspection we found that the paper and electronic policies, procedures and guidance that staff referred to when providing care and treatment to patients were out of date. The Trust had undertaken a major review of the Trusts policies and procedures and apart from the emergency department and medication policies, the majority were now current and reflected best practice.
- We found that although the wards and consultants offered a seven day service they were not always supported by other services. This limited the responsiveness and effectiveness of the service the hospital was able to offer and on occasions delayed discharge. For example there was no access to therapy staff, dieticians or speech and language therapists (SALT) at weekends on the stroke ward. Pharmacy services only available until midday at weekends, which impeded timely discharge for patients who were unable to obtain their discharge medication.
- We found that patients were always asked for their consent before any intervention and this was always appropriately recorded.
- There was good multidisciplinary working throughout the hospital.
- We observed that patients' nutritional needs were met. They were served a choice of foods and that therapeutic diets were managed well. Dietary supplements were given to people when prescribed.
- In general patients received timely effective pain relief.

Caring

- Patients and relatives we spoke with during the inspection were very complimentary about the service they received, and the caring and approachable attitude of the staff. Relatives were also involved in the planning of care and told us that they had access to sufficient information about their relative's condition.
- We saw caring and compassionate care being delivered throughout the hospital but in particular we observed staff in the critical care and outpatients and diagnostic and imaging department treating patients, relatives and visitors with respect and thoughtfulness.

Responsive

Summary of findings

- We found that the hospital did not always have sufficient capacity to meet the needs of the patients admitted.
- This meant that patients were often moved between wards during their stay, they were admitted to non-specialty beds where their own doctors were difficult to contact and consultant reviews less likely to occur. Women in labour often had to travel considerable distances to access maternity care when in labour because there was lack of capacity at their nearest hospital. In the emergency department patients were subject to overcrowding with no processes for requesting additional staff or diverting patients to other emergency departments. The lack of capacity had negative implications for the safe care and treatment patients.
- The wards must be supported in providing a full seven day service by appropriate numbers of support services such as radiology, physiotherapy and pharmacy.
- Patient flow through the hospital was limited by the availability of beds, caused by delayed discharges. In turn delayed discharges associated with provision of on-going support, rehabilitation and delays in take home medication, adversely impacted on the hospital's bed capacity. The discharge of patients was not managed in a timely manner, especially at weekends. This was raised as a concern at the last inspection.
- We also found that support for people with an acute medical condition or emergency care needs but who also had mental health needs was variable.
- Surgical referral to treatment times were not being met over consecutive months for surgical specialties. Theatres were not always effectively utilised and this affected performance.
- Improvements were needed for the day-care environment, as this did not provide sufficient privacy.
- Arrangements were in place to support people with disabilities and cognitive impairments, such as dementia. Translation services were available and information in alternative languages could be provided on request.
- The complaints process was understood by staff and patients had access to information to support them in raising concerns. Where complaints were raised, these were investigated and responded to. Where improvements were identified, these were communicated to staff through a range of methods.

Well Led

- The Trust had implemented a Special Measures Action plan following our last inspection. The action plan identified where issues had been raised during inspection and outlined actions to be taken by the Trust along with an agreed timescale. This action plan had been RAG rated on delivery of objectives.
- We found that the Trust had taken action to refocus its vision and mission strategy. However many of the leadership, organisational and developmental changes were in their infancy and had not had time to deliver the necessary changes to the patient experience.
- Work was in progress to develop the directorate strategic aims and principles. Although there was now a clear direction of focus in many of the services, others such as the End of Life team and midwifery unit lacked a clear strategy and strategic direction.
- We had concerns that the reduced resources for the End of Life team meant that the planned improvements were unsustainable and could not be implemented on current resources.
- Some services such as the midwifery service had been through a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. Although progress was being made to stabilise the midwifery service with appointments to a number of interim, acting and substantive posts, a number of staff remained unhappy.
- We received positive feedback about the changes instigated by the interim chief executive. Staff told us that the change in culture was 'seeping through every area of the hospital'. They told us that there was 'positivity in the air which is very exciting' and that 'management' was slowly becoming more visible and approachable to front line staff. They told us they felt more valued as an employee and encouraged to be better. Staff told us that they felt there were now shared goals and although things were far from perfect there was some direction at last.
- Governance arrangements throughout the hospital had been strengthened and were starting to provide more robust information to staff at all levels and to the Trust Board.

We saw areas of outstanding practice including:

Summary of findings

- The Nurse leadership in outpatients was outstanding with staff inspired to provide a good service to patients. The main outpatient's matron provided knowledgeable and inspirational support to staff whilst working hard to maintain and improve the service.

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

Importantly, the trust must:

- There must be sufficient numbers of suitably qualified, skilled, and experienced midwifery staff available to deliver safe patient care in a timely manner.
- The environment and facilities in which patients are cared for must be safe, well maintained, fit for purpose and meet with current best practice standards.
- The trust must ensure that all taps in clinical rooms are working effectively.
- The trust should ensure that clinical areas are not carpeted. Where clinical areas are carpeted they must be managed with effective risk assessment and cleaning regimes.
- There must be sufficient equipment in place to enable the safe delivery of care and treatment, that the equipment is regularly maintained and fit for purpose to reduce the risk to patients and staff.
- The trust must ensure the hospital has sufficient capacity to cope with the number of women in labour and new born babies on a day to day basis.
- The wards must be supported in providing a full seven day service by appropriate numbers of support services such as radiology, physiotherapy and pharmacy.
- There must be robust systems in place to monitor the safe management of medicines to ensure that national guidelines are reviewed appropriately and their implementation monitored.

In addition the trust should:

- Review the training provided to clinical staff on the Mental Capacity Act and DoLS to ensure all staff understand the relevance of this in relation to their work.
- The trust should ensure that surgical staff undertake required training in safety related subjects.
- The trust should continue to improve referral to treatment times across all specialities to ensure that patients are treated in an acceptable timeframe following referral to the service.
- Standardising inotropic infusions to avoid the risk of potential drug errors when staff engage in cross site working.
- There should be a formal vision and strategy for women's health services to enable the development of a modern maternity service which is woman centred, underpinned by a sound evidence base and benchmarked against best practice standards.
- Methods of maintaining the stability of leadership within the maternity department should be established.
- The routine administrative burden on maternity staff at weekends and out of hours should be reduced in order to free midwifery staff to look after patients.
- Staff should be encouraged to report non-clinical incidents in order that action can be taken to protect patients from avoidable harm.
- The electronic system for allocating NHS numbers to new born babies should be functioning, in order to avoid the risk of babies missing screening tests through a manual process with insufficient printers available.
- There should be a robust system in place to measure, monitor and analyse common causes of harm to women during pregnancy and childbirth.
- The trust should continue to improve Referral to Treatment times across all specialities to ensure that patients are treated in an acceptable timeframe following referral to the service.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	Overall we rated the emergency and urgent care department as Inadequate. We had concerns about the safety of the patients who were at times cared for in an overcrowded department by staff who did not have the time to care for them effectively. Overcrowding in the department was a serious and on-going risk. There was an emergency floor standard operational procedure dated July 2015 which provided a framework for all staff working within the emergency areas. This included roles and responsibilities for all staff both medical and nursing and escalation plans for patients in the department for up to 60 minutes, two hours, 3 hours, 3.5 hours and 4 hours. However, there was no guidance on what to do when the department was over crowded. There were no trigger factors for the number of patients in the department, the space available in the majors and resuscitation bays and the number of ambulances queuing. There were also no processes for requesting additional staff or diverting patients to other emergency departments. We saw a lack of incident reporting as staff told us they were too busy to report incidents. The use of a daily communications log by nursing staff at the end of a shift was used to share incidents which had occurred during their shift. Some of these issues should have been reported as a critical incident. However, there was evidence of learning from an incident through the trust's magazine 'Risk Wise'. There were no dedicated facilities for children and a lack of trained children's nurses. When children's nurses were in the department they were either looking after adult patients, which they were not trained to do or they were not always aware there were children in the department requiring their attention. Mortality and morbidity meetings were held every month to review the care of patients who had complications or an unexpected outcome within the department. Learning points were shared with staff.

Summary of findings

Adherence to infection control procedures were generally being followed although we did see instances where staff did not always wash their hands after examining or treating patients.
We found controlled drugs were being stored appropriately. However on reviewing the control drug register there were a number of discrepancies with record keeping which would not comply with the Medicines Act 1968 and the Safer Management of Controlled Drugs Regulations 2006.
There was evidence of poor record keeping and we saw three sets of children's records placed in an environment which breeched the records management regulations. Where daily audits of records were taking place, nothing had been done to address the shortfalls.
Processes were in place for the identification and management of adults and children at risk from abuse. Staff understood their responsibilities and were aware of safeguarding policies and procedures. All staff had safeguarding Level 3 training.
Overall there was insufficient observation of patients in the waiting area which may result in not detecting a deteriorating patient in a timely manner.
There was no rapid assessment intervention team for patients arriving by ambulance which provided rapid assessment of 'major' patients arriving in the department by senior medical staff.
Patients who attended by ambulance were greeted by nursing staff in the middle of the majors area. There was a verbal handover from the ambulance staff to the nursing staff which meant that on the whole, patients arriving by ambulance could be placed in the correct area quickly. However, this was often compromised due to the overcrowding of the department.
There was a designated phone line to the stroke team. We saw the stroke pathway used where a patient was rapidly triaged by the stroke nurse and referred to a consultant. Treatment commenced within one hour of the patient arriving in the department. The unit also had a remote telemedicine service available to provide 24 hour cover for acute stroke patients out of hours.

Summary of findings

There were problems with the number of medical staff in the department. The trust was actively addressing this and recruitment of sufficient medical staff to resource the department was on-going. The department also experienced a high use of agency nurses due to nursing staff shortages. The department did not have a full complement of registered children's nurses. Five new children's nurses had been recruited but these were not in post at the time of the inspection.

Due to the closeness of the channel tunnel, M20 and Dungeness nuclear power station, the trusts major incident procedure was being reviewed and training to support the procedures were in place. However, there was no major incident training for paediatrics.

Patient feedback about the service was mostly positive. All patients we met felt the service was good. In the CQCs national A&E survey (2014), seven out of 10 patients (both the William Harvey Hospital and the Queen Elizabeth Queen Mother Hospital) rated their overall experience of the A&E to be good.

Staff were well supported with good access to training, supervision and development. Evidence based guidance was used across a range of conditions but these were often out of date and some staff did not know how to access them.

The department participated in national and local audits about their clinical practice. However, the 2015/16 clinical audit programme for the urgent care & long term conditions division highlighted there were a number of audits undertaken by the department where there were no action plans to improve the outcomes for patients.

Some of the college of emergency medicine CEM audits demonstrated outcomes for patients may not be as good as expected. This may mean, improvements identified via the audit process may not result in improvements being made and as such patients may not receive best care.

The pain management policy was in a draft and was being developed in conjunction with the trust's medication policy. Patients in the department did not consistently receive timely pain relief. We saw records where there were incomplete pain scores and evidence of patients waiting over 90 minutes for pain relief.

Summary of findings

The notes we reviewed did not show food and drink had been offered to patients who had been in the department for more than two hours and the nurses communication log identified that on one shift patients had not been offered food or fluids for over 10 hours. This meant that people who were vulnerable or who had specific dietary needs would not have been identified.

The department had a practice development nurse who was responsible for planning, coordinating and delivering in house training and there was a programme of competency based training and development for each grade of staff. Staff appraisals took place with 75% of nursing staff receiving their appraisal.

Induction was given to all newly recruited nurses and medical staff, including agency nurses. All registered nurses were paediatric intensive life support (PILS) trained.

Junior doctors told us they felt well supported by the senior medical staff and received regular training. Education sessions took place every Friday morning for nursing and medical staff.

Patients were being asked for verbal consent to be treated and we heard doctors and nurses explaining the care and treatment they were receiving. We spoke with staff about the Mental Capacity Act 2005 and deprivation of liberty Standards (DoLS). Some staff understood the basic principles of the Act and could explain how the principles worked in practice in the department. However, three members of staff we spoke with did not know about DoLS.

We saw compassionate care given to children and patients in the minor's area and staff were trying to care for their patients as best as possible but due to the overcrowding and pace of the department it was difficult for staff to spend time with patients. The CQCs national A&E survey showed that staff explained what was happening and had time to listen to patients. However, we saw patients left on trolleys rather than beds consequently not receiving relief for pressure areas. We saw patients on trolleys and chairs in the corridor and patients stacked in the middle of the department as there were no bays available. Patients were having cannulas inserted in the corridors and patients were placed on chairs in the major's area.

Summary of findings

On a number of occasions we saw patient's privacy and dignity being compromised. For example; we saw patients being examined in the main corridor and an incident where patients' private areas were exposed to the public due to the curtains not being fully closed.

Patients with a mental health problem experienced long delays to be seen by the mental health team and there were no dedicated facilities for them to stay in the department whilst waiting to be seen.

Trusts in England were tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The department had struggled to meet this target consistently; its lowest performance was in January 2015 at 80.15%.

The management of the department were aware of the increasing demands on the department and were working on introducing new services to manage the demand.

Reconfiguration of the premises was underway to attempt to accommodate the increase in demand and improve the flow of patients through the department.

There was a clinical decisions unit (CDU) which took patients from the department when they may be waiting for over 12 hours for a decision to admit for further treatment or to be discharged out of the hospital. This ensured that no patient was left on a trolley in the department for more than 12 hours. However, a number of patients stayed on the CDU for more than three days and there were times where patients with a mental health condition would stay on the unit whilst waiting for a mental health assessment being looked after by staff with no mental health experience.

Translation/interpreter services were available at the hospital for use when patients whose first language was not English enter the department.

There was no strategy for the emergency department, this was being developed and in draft format. However, the urgent and long term conditions directorate was contributing to the trusts 'Developing our Future' five to ten year

Summary of findings

strategy. There was a vision for children's services in the department however; there were no plans for shared paediatric rotas and no plans for shared paediatric governance at this time.
A policy for managing how children should be treated was being drafted but at the time of the inspection there was no policy or guidance about how children should be assessed and treated.
Changes were being made to improve the flow of patients through the emergency care pathway. These changes were being tested out at the time of the inspection.
Monthly meetings were held to review incidents, complaints, progress on audit activity and other safety issues. This was attended by senior clinicians and managers.
The divisional risk register detailed the risks associated with poor patient flow, increased activity, delays in the department, and the lack of paediatric trained nurses at both emergency departments and staffing levels. These risks mirrored what staff and managers told us.
In CQCs report from 2014 the lack of visible leadership was highlighted as a concern. It would appear the directorate team had actioned this by having a shift coordinator role: a major's coordinator role and a matron.
However whilst there was visibility the three roles did not seem to work well together. This meant there were now three 3 nurses all supernumerary (the matron, the department coordinator and the majors coordinator) with no single person giving leadership, direction and supervision to the rest of the team.
There appeared to be a duplication of roles where there were now three senior roles coordinating the department which in itself causes blurring of the role boundaries. What appeared lacking was hands on visible leadership within the major's area, in particular the high use of agency staff created the need for strong clinical supervision and leadership to ensure the safety of those patients being cared for.
Patients were not seen in a reliable way and nobody seemed to know overall what the patient state was.

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We observed good leadership in the minor's area although we were told this was sometimes hampered by senior manager's interaction and interruption.
We found staff morale was improving since the last CQC inspection. However, there was a culture of acceptance where staff came to believe there was no point in escalating overcrowding as this was a daily occurrence. We asked six members of staff at what point would they escalate unsafe occupancy levels, they told us there was no limit to the number of patients that were in attendance so they would not report the levels.

Medical care (including older people's care)

Requires improvement

Overall, we found medical care services at The William Harvey Hospital required improvement in some aspects of patient safety. This is because we identified some concerns in relation to medical staffing, nursing staffing, especially at night, the storage and management of medicines, the management of confidential records and shortfalls in infection control procedures. Otherwise, we found that there were good systems to report and investigate safety incidents.
We found that treatment generally followed current guidance, but care assessments did not always consider or record the full range of people's needs and were not reflected in plans to individually address their care. We found that there were arrangements to ensure that staff were competent and confident to look after patients. However, medical staff were not always able to access adequate educational support to promote their professional development. Patients were cared for by a multi-disciplinary team working in a co-ordinated way and generally had access to some services seven days a week. However, services such as speech and language therapy and physiotherapy services were not available at weekends. Patients received adequate food and drink and were supported to eat and drink. Consent was obtained and recorded in line with relevant guidance and legislation and where patients lacked capacity to make decisions for themselves, staff acted in accordance with their obligations under the Mental Capacity Act 2005.

Summary of findings

We judged the caring aspects of medical care services were good. Patients and their relatives were positive about their experience of care and the kindness afforded them. They told us they received a high standard of care that met their needs. We observed compassionate care that promoted patients' privacy and dignity. Patients were involved in their care and treatment and were given the right amount of information to support their decision making and patients could get the emotional support they needed.

We judged that the responsiveness of medical care services required improvement. This was because there was insufficient bed capacity to meet the needs of patients. This resulted in almost half patients being moved at least once during their hospital stay. There were large numbers of patients in non-speciality beds and this had negative implications for their safe care and treatment. We also found that support for people with mental health needs was variable and the discharge of patients was not managed in a timely manner, especially at weekends.

We judged that Well Led was Good. There was an appropriate system of governance in medical care services and arrangements to monitor performance, quality and risk in which concerns were escalated to the trust board and key messages disseminated to staff. Staff acknowledged the steps that had been taken within the organisation to improve structures, processes and systems of accountability. They could discuss the trust philosophy and individual wards developed their own strategies which staff understood. We observed a caring and positive ethos. Staff acknowledged developments to embed a more cohesive culture of openness between senior managers and staff but reported that although the culture was improving, they did not always feel actively empowered or engaged. They felt improvement was reactive and focussed on short term issues.

There were examples of collaborative working with the voluntary sector and where patient representatives had been involved in developing and monitoring services.

Summary of findings

Surgery

Requires improvement

Patients who used the service experienced safe, effective and appropriate care and treatment and support that met their individual needs and protected their rights. The care delivered was planned and delivered in a way that promoted safety and ensured that peoples individual care needs were met. Staff provided care that was compassionate and all patients were treated with respect and dignity. Patients had their individual risks identified, monitored and managed and the quality of service provided was regularly reviewed. Staff were competent and knowledgeable about their specialties on both the surgical wards and in the theatre units. Mandatory training was not always up to date and there were gaps in the knowledge and understanding with regard to mental capacity. We found the clinical environments we visited to be very clean, as were equipment items. Hospital-acquired infections were monitored and rates of infection were in an acceptable range. Outcomes for patients were good and the departments followed national guidelines. Departments undertook frequent audits such as the theatre checklist and hand hygiene. Audits were analysed and the results cascaded to staff. Complaints were investigated and handled in line with trust policy. Patient complaints and comments were used as an improvement tool to positively impact on patient care delivery. Leadership in all areas had improved. Senior staff were visible, available and supportive to all staff.

Critical care

Good

We found the service delivered at the William Harvey Critical Care unit (CCU) to be safe, effective, caring, responsive and well led.
However, we continue to recognise a concern with delayed discharges from the unit which may suggest problems with patient flow elsewhere in the hospital. Capacity in the unit was also a concern, given the 100% occupancy rates despite the additional two unfunded beds in operation. The location of these beds was not desirable but staff had taken reasonable steps to minimise the risk to patients and staff. We also noted a robust strategy and vision in the unit, but were uncertain about whether it reflected the trust vision. We acknowledge a recent change to the trust

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leadership, and the on-going financial challenges, which presented an obstacle to achieving the plan. We recognised the frustrations of staff in terms of the stagnant situation in which they find themselves due to the environmental and financial restraints. The CCU did not always manage to achieve the national recommendation of ensuring a supernumerary shift leader for all shifts. However, we acknowledge that there has been a significant improvement in supernumerary management cover since our last inspection. A standardised approach to inotropic infusion concentrations (modifies the force of muscle contractions) and meeting national guidance for the x-ray checking of Nasogastric (NG) tubes had been implemented across all three sites.
We found effective systems in place to ensure safe care. The care delivery was continuously monitored and assessed to ensure a high quality care for the patients using the service. There was a positive culture towards reporting and learning from adverse events, and a refreshingly positive emphasis put on avoiding recurrence.
The care delivered reflected best practice and national guidance. Needs were risk assessed and the unit could demonstrate a track record of delivering harm free care. There were appropriate measures in place to ensure that patients were protected from the risk of acquiring hospital acquired infections, and staff were observed to follow trust infection control guidance.
Patients and their loved ones had their dignity and human rights respected and protected. The unit provided an ample and varied supply of information for relatives, and actively encouraged their feedback and comments. If a complaint was raised the service learned from the feedback given, and ensured that people felt listened to.
The relatives we talked with during the inspection were very complimentary about the service their loved ones had received, and the caring and approachable attitude of the staff. Relatives were also involved in the planning of care and told us that they had access to sufficient information about their loved ones' condition. Patients had their right to consent to care respected and, where possible,

Summary of findings

formal consent was obtained. Staff were found to make reasonable adjustments to reflect the needs of their patients. The service provided a person centred bereavement service for families.
There were suitable arrangements in place for dealing with foreseeable emergencies. Patients had their health needs risk assessed and balanced with safety, and had their rights and preferences taken into consideration. We noted effective systems to ensure patients' nutritional and pain needs were addressed and managed. Medication management reflected national and trust guidance.
The CCU had appropriate numbers of staff with the required skills to meet people's individual care needs. Staff were subject to competency-based learning and assessments, and were provided with support to learn, develop and progress professionally.
A multidisciplinary approach to care was noted, as was the provision of a seven day service. There was a consultant-led ward round twice daily which meant that patients conditions and progress were continuously monitored. There were effective systems in place to ensure that deteriorating patients had their care needs reviewed in a timely manner. This was also true of patients who were in ward areas as they had their conditions reviewed by the outreach team using an electronic monitoring system.
There was strong leadership in the CCU and staff expressed feeling valued and listened to. They voiced satisfaction with the local unit management and the support provided to them. Numerous steps had been put in place to address the culture concerns raised in the last inspection. Staff told us these measures had a positive impact on morale and on their working environment.

Maternity and gynaecology — **Requires improvement**

We found that the majority of issues identified in the previous report had not been addressed.
Since the last inspection the midwifery service had been through a period of instability of leadership. The lack of leadership, a culture of bullying and lack of strategic direction was felt throughout the midwifery team and had resulted in a lack of focus and direction for the obstetric service at the William Harvey Hospital for several months.

Summary of findings

Since April 2015 a number of interim, acting and substantive management posts had been filled and although a number of staff remained unhappy, progress was being made to stabilise the midwifery service.

There remained a problem with under staffing although the Trust was now actively recruiting to the vacancies. There remained a lack of capacity with the maternity units across the Trust closing on many occasions. This reduced the choice available and meant that women in labour had to travel more than 30 miles to the next available hospital.

There remained issues with the general environment and lack of equipment across the obstetric department. There was a shortage of basic medical equipment from medical devices.

The temperature on Folkestone ward and in the labour ward was causing distress to patients and staff working there. There were no en-suite facilities for women in labour, only one obstetric operating theatre for both emergency and elective procedures, little storage space available and the midwife led unit could not be kept secure because of a fire exit from the neighbouring ward.

The general environment across the hospital sites was visibly clean although the basic design and worn furnishings presented problems with regard to infection control. There was a lack of facilities to support women's partners during their stay. The bereavement suite was clinical in nature and not appropriate for women and their partners who had suffered the loss of a baby.

However throughout the problems with leadership and staff unrest during the year we noted that staff had continued to provide women with positive pregnancy and birth experiences. Women were usually involved in decisions about their care, and were kept up to date with their progress. The majority of feedback received was positive and the kind and caring attitude of the staff praised. Since the last inspection a thorough review of all relevant policies and procedures had taken place to ensure they met with current best practice.

There were mechanisms in place to enable staff to learn from any incident, accident or complaint

however we found there was under reporting of incidents across the maternity service especially non-clinical events. Clinical governance system and training had improved.
The majority of the obstetric records and medical notes we reviewed were well completed. However there was a risk that babies could miss the new born screening test as NHS numbers were allocated manually with insufficient printers in place. The hospital had systems in place to identify when patients who were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patients' risk.

Services for children and young people

Requires improvement

Performance showed a track record and steady improvements in safety. However, information about safety was not always comprehensive. The trust was using the Kent safeguarding children's board (KSCB) safeguarding procedures. These were not trust specific. The trust had not produced an East Kent University NHS Foundation Trust (EKUNFT) children and young people's safeguarding policy.
Padua ward, NICU and SCBU provided safe and comfortable environments for children. However, the waiting area in the WHH fracture clinic was not child friendly. The fracture clinic had a children's bay in the clinic which staff had decorated in child friendly décor. However, there was no designated waiting area for children and their families; waiting room conditions were cramped and overcrowded.
Gap analysis had been conducted to identify staff that needed up-to-date training in children and young people's safeguarding to an appropriate level. The training was being rolled out across the trust.
There was an increased risk that people could be harmed, due to medicines not being secure in children's ward areas and adult medicines being placed on top of a children's resuscitation trolley in the outpatients department. On Padua ward medicines fridge temperature had a number of omissions. A number of patient group directions (PGD's) were out of date.
Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at

Summary of findings

all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to people who use services.
Risks to people who use services were assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenges. People were involved in managing risks and risk assessments were person-centred, proportionate and reviewed regularly.
Staff recognised and responded appropriately to changes in risks to people who use services.
Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.
Children and young people had good outcomes because they received effective care and treatment that met their needs. People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Padua ward had a practice development nurse who monitored staff practice to ensure consistency.
Children and young people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.
There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and service accreditation. The trust had achieved level 1 UNICEF Baby Friendly accreditation for supporting breastfeeding and parent infant relationships by working with public services to improve standards of care.
Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were supported to deliver effective care and treatment through supervision and appraisal processes.

Summary of findings

When people received care from a range of different staff, teams or services, this was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of children and young people's needs.
When children and young people were due to move between services their needs were assessed early, with the involvement of all necessary staff, teams and services; discharge and transition plans took account of patients individual needs, circumstances, on-going care arrangements and expected outcomes. Children and young people were discharged at an appropriate time and when all necessary care arrangements were in place.
Staff could generally access the information they needed to assess, plan and deliver care to people in a timely way.
Consent to care and treatment was obtained in line with legislation and guidance. Children and young people were supported to make decisions.
Processes for seeking consent were appropriate.
Feedback from children, young people and families who used the service was mostly positive about the way staff treated people. Children and young people were treated with dignity, respect and kindness during interactions with staff and relationships with staff were positive.
Children, young people and their families were involved and encouraged to be partners in their care and in making decisions, with any support they needed. Staff spent time talking to children, young people and their parents. Children and young people were communicated with in a way they could understand. Children, young people and their families understood their care, treatment and condition. Parents told us staff worked with them to plan care and share decision-making about care and treatment.
Staff responded compassionately when patient's needed help. Staff took appropriate steps on the ward to ensure patient's privacy and confidentiality was respected.
Staff helped children, young people and their families to cope emotionally with their care and treatment. Patient's social needs were understood.

Summary of findings

Children and young people were supported to maintain and develop their relationships with those close to them, their social networks and community. Parents were facilitated to stay on the ward over night or in accommodation specifically provided for parents.

Children and young people's needs were met through the way services were organised and delivered. The importance of flexibility, choice and continuity of care was reflected in service provision. The needs of different patients were taken into account when planning and delivering care and treatment. Care and treatment was coordinated with other services and other providers.

Children and young people could access the right care at the right time. Access to care was managed to take account of patients' needs, including those with urgent needs.

The appointments system was easy to use and supported people to make appointments.

Waiting times, delays and cancellations were minimal and managed appropriately. Services ran on time. Patients were kept informed of any disruption to their care or treatment.

It was easy for people to complain or raise concerns and they were treated compassionately when they did so. Complaints and concerns were always taken seriously, responded to in a timely way and listened to. Improvements were made to the quality of care as a result of complaints and concerns.

The values for children and young people's services had been developed with elements such as compassion, dignity and equality. However, there was no long-term vision or strategy in place for children and young people's services. The trust had conducted a recent strategic review of children and young people's services, and concluded that the proposed strategy of children and young people's services operating from one site was not viable. At the time of our inspection there was no decision pending on what the vision or strategy would be for children and young people's services.

Children and young people's staff were unaware of the trust's strategic goals as the trust had not made a final decision about the future strategy for children and young people's services.

Summary of findings

The board and other levels of governance within the organization had undergone changes in the past 12 months. The chief nurse and director of quality had been instated as the children and young people's services lead. The service's structures, processes and systems of accountability were set out and understood by staff.

There was an effective process in place to identify, understand, monitor and address current and future risks. Performance issues were escalated to the relevant committees and the board through clear structures and processes. Clinical and internal audit processes were in place.

The leadership was knowledgeable about quality issues and understood what the challenges to children and young people's services were, and took action to address them. However, monitoring at WHH was a challenge due to the matron being based in Maidstone.

Leaders at every level prioritised safe, high quality, compassionate care and promoted equality and diversity. The culture change programme encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. However, staff reported that ward managers for children and young people's services had been overlooked for administrative support.

There was evidence that the leadership had introduced processes that would actively shape the culture through effective engagement with staff, people who use services and their representatives and stakeholders. Senior leaders encouraged a culture of collective responsibility between teams and services. But, these processes were not embedded.

The children's and young people's service was proactively engaging with and involving all staff to ensure that the voices of staff were heard and acted on. The leadership actively promoted staff empowerment to drive improvement and a culture where the benefit of raising concerns was valued.

Senior leaders focus was on continuous learning and improvement at all levels of the organisation. Safe innovation was being supported and staff had objectives focused on improvements.

Summary of findings

End of life care

Requires improvement

The trust's specialist palliative care team demonstrated a high level of specialist knowledge. The team provided individualised advice and support for patients with complex symptoms and supported staff on the wards across the hospital. We found reduced resources for the team and concerns regarding sustainability of the service. The planned improvements could not be implemented on current resources.

There remained a lack of Trust Board direction for end of life care with a non-unified approach across the various wards and departments. There was limited end of life care training and use of the trust resource pack was patchy and not kept up to date. Wards struggled with staffing levels and there were no extra staff in place to support end of life care.

All staff we spoke with, both clinical and non-clinical, demonstrated a very high level of care, pride and attention to detail in the provision of a good quality service for patients identified as end of life. Patients and families we spoke with described good quality care from staff. The trust worked with the East Kent regional strategy in line with evidence based practice and guidance.

Outpatients and diagnostic imaging

Good

The Outpatient department was well led and had improved since implementing an outpatient improvement strategy. Despite the strategy being relatively new, through structured audit and review the department was able to evidence improvements in health records management, call centre management, referral to treatment (RTT) processes, increased opening hours, clinic capacity and improved patient experience.

Although there was still improvement required in referral to treatment pathways the outpatients department and trust demonstrated a commitment to continuing to improve the service long term.

As a part of the strategy the trust had pulled its outpatient services from fifteen locations to six. We inspected five of these locations during our visit. Managers and staff working in the department understood the strategy and there was a real sense that staff were proud of the improvements that had

Summary of findings

been made. Progress with the strategy was monitored during weekly strategy meetings with the senior team and fed down to department staff through staff meetings and bulletins.
Evidence based assessment, care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines by appropriately trained and qualified staff.
A multi-disciplinary team approach was evident across all the services provided from the outpatients and diagnostic imaging department.
We observed a shared responsibility for care and treatment delivery. Staff were trained and assessed as competent before using new equipment or performing aspects of their roles.
We saw caring and compassionate care delivered by all staff working at outpatients and diagnostic imaging department. We observed throughout the outpatients department that staff treated patients, relatives and visitors in a respectful manner.
Nurse management and nursing care was particularly good. Nurses were well informed, competent and went the extra mile to improve patient's journey through their department. Nurses and receptionists followed a 'Meet and Greet' protocol to ensure that patients received a consistently high level of communication and service from staff in the department.

William Harvey Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to William Harvey Hospital

The William Harvey Hospital (WHH) in Ashford, Kent is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust (EKUFT). EKUHFT became a Foundation Trust in 2009. Foundation trusts are still part of the NHS but they are able to provide and manage their services to meet the needs and priorities of the local community, as they are free from central Government control. However they are still accountable to Parliament and have to comply with a framework of national standards.

EKUHFT provides local services primarily for the people living in Kent. The Trust serves a population of approximately 759,000 and employs approximately 6,779 whole time equivalent staff.

The William Harvey Hospital (WHH) is an acute 476 bedded hospital providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric and neonatal Intensive care services. The hospital has a specialist cardiology unit undertaking angiography, angioplasty, an analytical robotics laboratory that reports all East Kent's General Practitioner (GP) activity and a robotic pharmacy facility. A single Head and Neck Unit for East Kent has recently been established and includes centralised maxillofacial services with all specialist head and neck cancer surgery co-located on the site. WHH has a post graduate teaching centre and staff accommodation.

Following our last inspection of the Trust in March 2014 when we found many of the services provided to be inadequate, EKUHFT was placed into special measures by the regulator Monitor. This announced inspection was undertaken to monitor and assess what progress the Trust had made in addressing our concerns.

We carried out an announced inspection of EKUHFT between 13- 17 July 2015. We also undertook unannounced visits the following week on 29 July 2015.

At this inspection although we found the hospital overall to require improvement we noted there had been improvements made in the majority of services we inspected.

Our inspection team

Our inspection team was led by:

Chair: Ted Baker, Deputy Chief Inspector of Hospitals, CQC

Head of Hospital Inspections: Alan Thorne, CQC

The hospital was visited by a team of 50 people including CQC inspectors, analysts and a variety of specialists.

There were consultants in emergency medicine, medical care, surgery, haematology, cardiology and palliative care medicine; an anaesthetist, and junior doctors. The team

Detailed findings

also included midwives, nurses with backgrounds in surgery, medicine, paediatrics, critical care and palliative care, board-level experience, a student nurse and two experts by experience. Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

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

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospital, including doctors, nurses, allied health professionals, administration and other staff. We also interviewed senior members of staff at the hospital.

Facts and data about William Harvey Hospital

Context

The William Harvey Hospital (WHH) is one of five hospitals operated by East Kent University Hospitals NHS Foundation Trust (EKUHFT) and is located in Ashford, Kent. East Kent Hospitals University NHS Foundation Trust provides acute healthcare services to Dover; Canterbury; Thanet; Shepway and Ashford.

- 2013 data indicates that deprivation in the areas of Dover; Canterbury; Shepway and Ashford is significantly better than the England average while that for Thanet is significantly worse than the England average.
- The proportion of Black, Asian and Minority Ethnic (BAME) residents is less than half than the England average of 14.6%. For example in the 2011 census the proportion of residents who classed themselves as white British in Dover was 96.5%.
- Child deprivation in Dover, Thanet and Shepway is significantly worse than the England average
- Violent crime significantly worse across the region than the England average.
- Adult health and lifestyle is the same or slightly better than the England average apart from Dover where there is a higher prevalence of smoking.
- The life expectancy for men and women in Thanet is worse than the England average but is the same of better in the other areas.

Detailed findings

Activity

- Across the Trust there are approximately 1,190 beds with 1,047 general and acute and 59 day beds. There are 53 maternity with 4 day beds. Critical care has 27 beds.
- The WHH hospital has a total of 476 beds and provides a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services.
- The Trust employs Staff: 6,778 staff of which 872 are medical staff, 2,148 nursing and midwifery and 3,758 other staff.
- In 2014/2015 there were approximately 93,509 admissions with 137,664 elective day case admissions.
- There were approximately 727,216 outpatients seen and 204,685 attendances at the emergency departments.

Key intelligence indicators

Safety

- Rates of Clostridium difficile and MSSA bacteraemia are less than those for England
- There have been 8 cases of healthcare attributable MRSA bacteraemia infections.
- Medical staffing skill mix across all staff grades are equal to England Average.
- Bank and agency staff usage higher than the national average.
- 71 Serious incidents were reported to have occurred between June 2014 and May 2015.
- 60 of these occurred in ward areas, labour ward and delivery and accident and emergency.
- There appears to have been a steady decline in the prevalence rate of Pressure Ulcers, and despite a rise at the end of last year, the rate has continued to fall into 2015
- The rate of falls with harm has fluctuated over the year but has seen a rise since Jan 2015.
- The rate of catheterised urinary tract infections has also fluctuated and seen a rise since Feb 2015.
- There is no evidence of elevated risks from the Hospital Standardised Mortality Ratio indicators.

Effective

- The William Harvey Hospital performed slightly better in the Clinical practice in England (discharge) section by recording scores better than the England Average for three out of the seven standards audited.
- In the Hip Fracture Audit the William Harvey Hospital scored six out of the nine comparable standards which were greater than the England average.
- In the National Emergency Laparotomy Audit 2014 the William Harvey Hospital was compliant with 12 of the 28 standards
- The trust performed the same as other trusts for the Effective questions in the A&E Survey.
- Unplanned re-attendance rate to A&E within seven days has remained around twice the 5% standard and above the England average for over two years.
- SSNAP (July 13 - Sep14): The William Harvey Hospital is rated A.
- MINAP (2013/14):Care of patients with nSTEMI Recorded scores less than the England average for nSTEMI patients seen by a cardiologist or a member of team
- Recorded scores higher than the England average for nSTEMI patients admitted to cardiac unit or ward
- Recorded scores less than the England average for nSTEMI patients that were referred for/had angiography during admission including angiography planned after discharge
- In the Heart Failure Audit 2012/13 the hospital performed badly in both the clinical practice in England (in-hospital care) and clinical practice in England discharge sections.

Caring

- There were mixed results from the cancer patient experience survey; The Trust scored below the England average for Patient-Led Assessments of the Care in the sections of Cleanliness, Food and Facilities.
- In the CQC In-patient survey results the Trust scored “about the same” as other trusts.
- A slight increase in the number complaints in 2013/14 was noted compared to 2012/13
- The Trusts score in the Family and Friends Test was below the England average between December 2013 to November 2014.
- CQC assessed the Trust against 96 indicators and found there was a risk in three and an elevated risk in a further six indicators.

Responsive

- The top three causes for delayed transfers of care included waiting for further NHS non acute care, patient or family choice and awaiting residential home placement or availability.

Detailed findings

- The Trust's bed occupancy rate is above that of the 85% standard after which the quality of care provided begins to fall.
- Average Length of Stay (ALoS) at Trust-level for both elective and emergency admissions is generally lower than that of England
- For elective admissions ALoS for the specialities with the highest number of admissions is less than that for England for that speciality.
- For Non-elective admissions ALoS for two of the three specialities (urology and vascular surgery) with the highest number of admissions is greater than that of England for the speciality.
- Although maternity bed occupancy fell in Q4 2014/15 the rate has been consistently worse than the England average.

Well-led

- Sickness absence rates for the trust are always below that for England.
- Trust was worse than expected for the Clinical Supervision and Feedback sections of the GMC (General Medical Council) national training Scheme.
- The Trust performed badly in the NHS Staff survey as a large majority of the indicators in the staff survey were negative.

Inspection history

- The William Harvey Hospital (WHH) has previously been inspected by CQC in 2011, 2012, 2013. This is the second comprehensive inspection of the WHH.
- Following the last comprehensive inspection undertaken in March 2014 The Trust was put into 'Special Measures' by Monitor, the Foundation Trust regulator as the core services inspected were assessed as 'inadequate'.

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

The emergency department at the William Harvey Hospital in Ashford provided a 24-hour service, seven days a week and was part of the urgent and long term conditions directorate of the trust. The department was designated as a trauma centre with approximately 199, 89 patients being seen every year. Overall attendances in the department were 180,019 for the year April 2013 to March 2104. Approximately 20% of these attendances were children.

The main reception was staffed 24 hours a day. Within the main department there were 12 treatment rooms and three side rooms, one for gynaecological patients; a four-bed resuscitation area and a minor injuries/ treatment area. The minor's area had four cubicles with trolleys, an eye examination room, a patient's assessment room for ECGs and examinations and two seated areas.

There was also a clinical decision unit (CDU) which was a service where either a GP or another health care professional may refer for a specialist same day review, assessment and treatment for specified conditions managed by fixed protocols. A trial was underway to determine whether the CDU could work as an acute medical assessment unit to improve the flow of patients through the urgent and emergency care pathway and as such was being run by two acute physicians.

The department used the CDU to transfer their patients if they needed further treatment or were waiting to be seen by the integrated discharge team. The CDU was also used to transfer patients if they had been waiting in the department for more than 12 hours.

The department did not have a separate children's emergency department, children's were treated and cared for alongside adult patients. The majority of time children were being cared for by nurses not trained to look after children.

The William Harvey Hospital in Ashford was part of the emergency care services provided by the trust.

There other services were located on three other sites; the Queen Elizabeth Queen Mother Hospital in Margate, the minor injuries unit at the Kent and Canterbury Hospital and the minor injuries unit at the Buckland Hospital. These three sites are reported on in separate reports. However, services at all sites were managed by the urgent and long term conditions directorate.

We spoke with 12 patients, six relatives and 38 staff, including consultants, middle grade doctors, senior managers, nurses, ambulance staff, domestics, and security staff. We observed care and treatment and looked at five treatment records. We also reviewed some of the trust's own quality monitoring information and data.

Urgent and emergency services

Summary of findings

Overall we rated the emergency and urgent care department as inadequate.

We had concerns about the safety of the patients who were at times cared for in an overcrowded department by staff who did not have the time to care for them effectively.

Overcrowding in the department was a serious and on-going risk. There was an emergency floor standard operational procedure dated July 2015 which provided a framework for all staff working within the emergency areas. This included roles and responsibilities for all staff both medical and nursing and escalation plans for patients in the department for up to 60 minutes, two hours, 3 hours, 3.5 hours and 4 hours. However, there was no guidance on what to do when the department was over crowded.

There were no trigger factors for the number of patients in the department, the space available in the majors and resuscitation bays and the number of ambulances queuing. There were also no processes for requesting additional staff or diverting patients to other emergency departments.

We saw a lack of incident reporting as staff told us they were too busy to report incidents. The use of a daily communications log by nursing staff at the end of a shift was used to share incidents which had occurred during their shift. Some of these issues should have been reported as a critical incident. However, there was evidence of learning from an incident through the trust's magazine 'Risk Wise'.

There were no dedicated facilities for children and a lack of trained children's nurses. When children's nurses were in the department they were either looking after adult patients, which they were not trained to do or they were not always aware there were children in the department requiring their attention.

Mortality and morbidity meetings were held every month to review the care of patients who had complications or an unexpected outcome within the department. Learning points were shared with staff.

Adherence to infection control procedures were generally being followed although we did see instances where staff did not always wash their hands after examining or treating patients.

We found controlled drugs were being stored appropriately. However on reviewing the control drug register there were a number of discrepancies with record keeping which would not comply with the Medicines Act 1968 and the Safer Management of Controlled Drugs Regulations 2006.

There was evidence of poor record keeping and we saw three sets of children's records placed in an environment which breeched the records management regulations. Where daily audits of records were taking place, nothing had been done to address the shortfalls.

Processes were in place for the identification and management of adults and children at risk from abuse. Staff understood their responsibilities and were aware of safeguarding policies and procedures. All staff had safeguarding Level 3 training.

Overall there was insufficient observation of patients in the waiting area which may result in not detecting a deteriorating patient in a timely manner.

There was no rapid assessment intervention team for patients arriving by ambulance which provided rapid assessment of 'major' patients arriving in the department by senior medical staff.

Patients who attended by ambulance were greeted by nursing staff in the middle of the majors area. There was a verbal handover from the ambulance staff to the nursing staff which meant that on the whole, patients arriving by ambulance could be placed in the correct area quickly. However, this was often compromised due to the overcrowding of the department.

There was a designated phone line to the stroke team. We saw the stroke pathway used where a patient was rapidly triaged by the stroke nurse and referred to a consultant. Treatment commenced within one hour of the patient arriving in the department. The unit also had a remote telemedicine service available to provide 24 hour cover for acute stroke patients out of hours.

There were problems with the number of medical staff in the department. The trust was actively addressing

this and recruitment of sufficient medical staff to resource the department was on-going. The department also experienced a high use of agency nurses due to nursing staff shortages.

The department did not have a full complement of registered children's nurses. Five new children's nurses had been recruited but these were not in post at the time of the inspection.

Due to the closeness of the channel tunnel, M20 and Dungeness nuclear power station, the trusts major incident procedure was being reviewed and training to support the procedures were in place however, there was no major incident training for paediatrics

Patient feedback about the service was mostly positive. All patients we met felt the service was good. In the CQCs national A&E survey (2014), seven out of 10 patients (both the William Harvey Hospital and the Queen Elizabeth Queen Mother Hospital) rated their overall experience of the A&E to be good.

Staff were well supported with good access to training, supervision and development. Evidence based guidance was used across a range of conditions but these were often out of date and some staff did not know how to access them.

The department participated in national and local audits about their clinical practice. However, the 2015/16 clinical audit programme for the urgent care & long term conditions division highlighted there were a number of audits undertaken by the department where there were no action plans to improve the outcomes for patients.

Some of the college of emergency medicine CEM audits demonstrated outcomes for patients may not be as good as expected. This may mean, improvements identified via the audit process may not result in improvements being made and as such patients may not receive best care.

The pain management policy was in a draft and was being developed in conjunction with the trust's medication policy. Patients in the department did not consistently receive timely pain relief. We saw records where there were incomplete pain scores and evidence of patients waiting over 90 minutes for pain relief.

The notes we reviewed did not show food and drink had been offered to patients who had been in the department for more than two hours and the nurses communication log identified that on one shift patients had not been offered food or fluids for over 10 hours. This meant that people who were vulnerable or who had specific dietary needs would not have been identified.

The department had a practice development nurse who was responsible for planning, coordinating and delivering in house training and there was a programme of competency based training and development for each grade of staff. Staff appraisals took place with 75% of nursing staff receiving their appraisal.

Induction was given to all newly recruited nurses and medical staff, including agency nurses. All registered nurses were paediatric intensive life support (PILS) trained.

Junior doctors told us they felt well supported by the senior medical staff and received regular training. Education sessions took place every Friday morning for nursing and medical staff.

Patients were being asked for verbal consent to be treated and we heard doctors and nurses explaining the care and treatment they were receiving. We spoke with staff about the Mental Capacity Act 2005 and deprivation of liberty Standards (DoLS). Some staff understood the basic principles of the Act and could explain how the principles worked in practice in the department. However, three members of staff we spoke with did not know about DoLS.

We saw compassionate care given to children and patients in the minor's area and staff were trying to care for their patients as best as possible but due to the overcrowding and pace of the department it was difficult for staff to spend time with patients.

The CQCs national A&E survey showed that staff explained what was happening and had time to listen to patients. However, we saw patients left on trolleys rather than beds consequently not receiving relief for pressure areas. We saw patients on trolleys and chairs in the

corridor and patients stacked in the middle of the department as there were no bays available. Patients were having cannulas inserted in the corridors and patients were placed on chairs in the major's area.

On a number of occasions we saw patient's privacy and dignity being compromised. For example; we saw patients being examined in the main corridor and an incident where patients' private areas were exposed to the public due to the curtains not being fully closed.

Patients with a mental health problem experienced long delays to be seen by the mental health team and there were no dedicated facilities for them to stay in the department whilst waiting to be seen.

Trusts in England were tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The department had struggled to meet this target consistently; its lowest performance was in January 2015 at 80.15%.

The management of the department were aware of the increasing demands on the department and were working on introducing new services to manage the demand.

Reconfiguration of the premises was underway to attempt to accommodate the increase in demand and improve the flow of patients through the department.

There was a clinical decisions unit (CDU) which took patients from the department when they may be waiting for over 12 hours for a decision to admit for further treatment or to be discharged out of the hospital. This ensured that no patient was left on a trolley in the department for more than 12 hours.

However, a number of patients stayed on the CDU for more than three days and there were times where patients with a mental health condition would stay on the unit whilst waiting for a mental health assessment being looked after by staff with no mental health experience.

Translation/interpreter services were available at the hospital for use when patients whose first language was not English enter the department.

There was no strategy for the emergency department, this was being developed and in draft format. However, the urgent and long term conditions directorate was contributing to the trusts 'Developing our Future' five to ten year strategy. There was a vision for children's services in the department however; there were no plans for shared paediatric rotas and no plans for shared paediatric governance at this time.

A policy for managing how children should be treated was being drafted but at the time of the inspection there was no policy or guidance about how children should be assessed and treated.

Changes were being made to improve the flow of patients through the emergency care pathway. These changes were being tested out at the time of the inspection.

Monthly meetings were held to review incidents, complaints, progress on audit activity and other safety issues. This was attended by senior clinicians and managers.

The divisional risk register detailed the risks associated with poor patient flow, increased activity, delays in the department, and the lack of paediatric trained nurses at both emergency departments and staffing levels. These risks mirrored what staff and managers told us.

In CQCs report from 2014 the lack of visible leadership was highlighted as a concern. It would appear the directorate team had actioned this by having a shift coordinator role: a major's coordinator role and a matron.

However whilst there was visibility the three roles did not seem to work well together. This meant there were now three 3 nurses all supernumerary (the matron, the department coordinator and the majors coordinator) with no single person giving leadership, direction and supervision to the rest of the team.

There appeared to be a duplication of roles where there were now three senior roles coordinating the department which in itself causes blurring of the role boundaries. What appeared lacking was hands on

Urgent and emergency services

visible leadership within the major's area, in particular the high use of agency staff created the need for strong clinical supervision and leadership to ensure the safety of those patients being cared for.

Patients were not seen in a reliable way and nobody seemed to know overall what the patient state was. We observed good leadership in the minor's area although we were told this was sometimes hampered by senior manager's interaction and interruption.

We found staff morale was improving since the last CQC inspection. However, there was a culture of acceptance where staff came to believe there was no point in escalating overcrowding as this was a daily occurrence. We asked six members of staff at what point would they escalate unsafe occupancy levels, they told us there was no limit to the number of patients that were in attendance so they would not report the levels.

Are urgent and emergency services safe?

Inadequate

We have rated the safety of this department as inadequate. This was because we identified a number of incidences of poor practice.

We saw a lack of incident reporting as staff told us they were too busy to report incidents. The use of a daily communications log by nursing staff at the end of a shift was used to share incidents which had occurred during their shift. Some of these should have been reported as a critical incident. However, there was evidence of learning from an incident through the trusts magazine 'Risk Wise'.

There were no dedicated facilities for children and a lack of trained children's nurses. When children's nurses were in the department they were either looking after adult patients, which they were not trained to do or they were not always aware there were children in the department requiring their care.

Mortality and morbidity meetings were held every month to review the care of patients who had complications or an unexpected outcome within the department. Learning points were shared with staff.

Adherence to infection control procedures were generally being followed although we did see instances where staff did not always wash their hands after examining or treating patients.

We found controlled drugs were being stored appropriately. However, on reviewing the control drug register there were a number of discrepancies with record keeping which would not comply with the Medicines Act 1968 and the Safer Management of Controlled Drugs Regulations 2006.

There was evidence of poor record keeping and we saw three sets of children's records placed in an environment which breeched the records management regulations. Where daily audits of records were taking place, nothing was done to address the shortfalls.

Processes were in place for the identification and management of adults and children at risk from abuse. Staff understood their responsibilities and were aware of

safeguarding policies and procedures. All staff had safeguarding Level 3 training. Most nursing staff were up to date with mandatory training however, mandatory training for medical staff could be improved.

Overall there was insufficient observation of patients in the waiting area which may result in not detecting a deteriorating patient in a timely manner.

There was no rapid assessment intervention team for patients arriving by ambulance which provide early assessment of 'major' patients arriving in the department by senior medical staff.

Patients who attended by ambulance were greeted by nursing staff in the middle of the majors area. There was a verbal handover from the ambulance staff to the nursing staff which meant that on the whole, patients arriving by ambulance could be placed in the correct area quickly. However, this was often compromised due to the overcrowding of the department.

There was a designated phone line to the stroke team. We saw the stroke pathway used where a patient was rapidly triaged by the stroke nurse and referred to a consultant. Treatment commenced within one hour of the patient arriving in the department. The unit also had a remote telemedicine service available to provide 24 hour cover for acute stroke patients out of hours. A consultant specialising in stroke care would be on call.

Overcrowding in the department was a serious and on-going risk. There was an emergency floor standard operational procedure dated July 2015 which provided a framework for all staff working within the emergency areas. This included roles and responsibilities for all staff both medical and nursing and escalation plans for patients in the department for up to 60 minutes, two hours, 3 hours, 3.5 hours and 4 hours. However there was no guidance on what to do when the department was over crowded.

There were no trigger factors for the number of patients in the department, the space available in the majors and resuscitation and the number of ambulances queuing. There were also no processes for requesting additional staff and diverting patients to other emergency departments.

There were problems with the number of medical staff in the department. The trust was actively addressing this and recruitment of sufficient medical staff to resource the department was on-going. The department also experienced high use of agency nurses due to nursing staff shortages.

The department did not have a full complement of registered children's nurses. Five new children's nurses had been recruited but these were not in post at the time of the inspection.

Incidents

- The department had a CQC inspection in 2014 which also rated this domain to be inadequate. For the period January 2015 to April 2015, there were a total of 196 incidents reported in the department with 148 resulting in no harm to the patients, 43 resulting in low harm, five resulting in moderate harm and three being reported to StEIS. StEIS is a patient safety reporting and learning framework. Over 50% (106) of incidents reported were relating to patients arriving in the department with a pressure ulcer. Three members of staff told us they did not report incidents on Datix as it was too time consuming. This was a similar finding to the inspection in 2014.
- Staff knew how to report an incident but there was low incident reporting due to staff documenting their concerns via a communication log to the matron at the end of each shift. This log would record any events or issues that affected the smooth running of the shift.
- Whilst these records kept the matron up to date on patient flows and technical issues, a number of issues should have been reported as a critical incident. For example: notes from the 27th June 2015 to the 14th July 2015 demonstrated overly high occupancy levels such as: 56 and 60 patients in the emergency department at any one time along with comments such as: 'we were told to do the minimum necessary to ensure patients safety' and 'do observations on patients and make sure patients have wrist bands on'.
- The log also included incidents where patients who were categorised as needing to be cared for in the majors area but due to overcrowding, patients were being placed in the minors area. This could put patients at risk as the level of nursing care and observation would not be at its optimum.

- Issues were also raised via the communications log relating to the lack of access to computers due to internet problems resulting in lack of access to local guidelines and protocols; the lack of a band 7 nurse to oversee the department, patients being delayed in the department for 11 hours, a diabetic patient not being fed whilst in their care, other patients not being fed or given a drink for over 10 hours and delayed transfers of patients from the Kent and Canterbury Emergency Centre for over eight hours.
- Staff told us their main concern was the department being overly busy and at times became unsafe due to overcrowding.
- However, the trust had a magazine 'Risk Wise' which included learning from incidents. An example from an incident was included in the autumn 2014 edition where there was a missed case of sepsis in a patient with diabetes. The root cause analysis showed that blood cultures and arterial gases should have been taken earlier. The learning for staff was that documenting observations and decisions should be clearer in the patient notes and an improvement plan in the management of sepsis was underway.
- There were a set of three incidents relating to inadequate transfer arrangements and failure to implement the trusts transfer policy and the transfer situation background assessment recommendation (SBAR). SBAR is a communications tool used to enhance clinical decision making. This resulted in patients not being cared for appropriately. The learning from these incidents was to improve documentation and ensure better communication amongst medical and nursing staff.
- Mortality and morbidity meetings were held every month to review the care of patients who had complications or an unexpected outcome within the department. Learning points were shared with staff.
- We spoke with three members of staff who could not tell us about the duty of candour. The duty of candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other relevant person within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has or may have occurred.
- We saw patients' privacy and dignity being compromised for example; we saw patients being examined in the main corridor and an incident where a patients' private areas were exposed to the public due to the curtains not being fully closed. We had also received a complaint from a patient whose privacy and dignity had been compromised.
- Patient's medical histories were taken in the main area where the ambulance crews would bring patients into the department for handover to staff. Any member of the public or patient would be able to hear these conversations.

Cleanliness, infection control and hygiene

- In the CQCs national A&E survey, 9.6 patients out of 10 described the emergency departments as being clean.
- The department reported there were no incidents of MRSA (methicillin resistant staphylococcus aureus) or (C diff) clostridium difficile in the last twelve months.
- The department was mostly clean and we saw there was a fast response for deep cleaning for a side room once a patient had been transferred out of the department.
- The department had a 'hygiene code and environmental audit' undertaken in June 2015 which showed an overall compliance of 85%. Areas of non-compliance included equipment being left on the floor due to lack of space, some staff not having their hair tied back and some staff wearing watches. However, the department had 100% compliance with the trusts own clinical hygiene standards in June 2015.
- We observed all staff were 'bare below the elbows' apart from one doctor who wore sleeves to the wrists. This was brought to their attention at the time of the inspection. Protective clothing and equipment such as gloves and aprons were available and used by staff.
- The trusts' audit of hand hygiene showed 100% with personal protective equipment (PPE) standards. However, we saw poor hand washing in the triage area

and noted a number of medical staff not washing their hands when leaving the resuscitation area. We saw one member of staff examining a foot and then going to a computer without washing their hands.

Environment and equipment

- The department was generally well laid out however; at busy times overcrowding was an issue. We observed majors' patients were cared for in the minor's area and the corridors. Staff could not see adults or children in the waiting areas. This meant that if a patient's condition deteriorated it might go unnoticed.
- There were no separate facilities for children, no separate area for children to wait and no separate paediatric treatment area. This meant that children were exposed to adults who may be aggressive or abusive. This was also the case in the minors and majors areas. There was a small parent's room but this room could not be seen by nursing staff.
- The minor treatment area was not secure and was open to the waiting room. Members of the public could walk through the minor's areas without being stopped.
- The resuscitation bays were well stocked. All had a similar layout and drawers with equipment and medical supplies were colour coded for easier identification.
- Security arrangements were adequate. In the CQCs national A&E survey, 9.6 out of ten patients said they did not feel threatened in the A&E departments.
- The area in the department for staff to use computers and input patient details had recently been re-sited. The walls of this area were high which meant staff could not see patients in the main treatment area.
- We checked a range of equipment such as resuscitation trolleys, defibrillators and trolleys. All were in order and checked regularly.
- There were appropriate arrangements for the segregation, storage and disposal of waste.

Medicines (includes medical gases and contract media)

- Controlled drugs were stored appropriately. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential misuse. However on reviewing the control drug register there were a number of discrepancies with record keeping which would not comply with the Medicines Act 1968 and the Safer Management of Controlled Drugs Regulations 2006.
- We observed seven instances where there lacked a counter signatory signature for giving a controlled drug and two instances where a patients name had not been entered.

These were:

4 July 2015 Fentanyl 500 mgs/10 ml

15 May 2015 Midalozan 5mg/5 ml

8 July 2015 Morphine 10 mgs

9 February 2015 morphine

30 March 2015 Morphine 10 mgs

4 April 2015 Morphine 10 mgs

6 April 2015 Morphine 10mgs

01 June – no patient name

02 February – no patient name

- We were told controlled drugs errors/issues were not reported as an incident and we were told of an incident where an agency nurse almost administered a controlled drug but was stopped just before being administered. This was a near miss and should have been reported as an incident.
- We observed the fridge for storing drugs was unlocked and the drawers for holding drugs was also unlocked and could be accessed by someone passing by the resuscitation area.
- We observed the protocol for giving an intravenous infusion not being followed as a nurse had added a drug to the infusion and was about to give it to the patient without being checked by another nurse. We brought this to the attention of the nurse in charge of the department.
- There was a policy for the management of medical gases and a matron from the department would attend the medical gases committee which reported to the drugs and therapeutics committee on a three monthly basis.

- Medications for patients to take home were in good supply which meant they could be discharged in a timelier manner.
- In the CQCs national A&E survey, 9.4 patients out of ten said the purpose of new medicines was explained before they left the department. However, only 4.6 patients out of 10 said they were told about the possible side effects of those prescribed new medicines whilst in the department.

Records

- The department used a white board to track the patient's journey through the department. This included: the patients name, time of arrival in the ED and the named nurse in charge of each patient.
- The department carried out daily checks of patients records. This showed not all patient properties had been checked, no primary observation were carried out and four records had no pain scores documented. These checks were incomplete and some had no signature. When asked what action would be taken to improve record keeping we were told no action would be taken.
- We looked at four sets of patient records EWS scores and regular observations were not recorded. There were also no waterlow scores documented. A waterlow score card is a tool used to assess the risk of a patient developing a pressure sore.
- We found three children's palliative care patient records on a shelf in the resuscitation area. These were records of children who were treated in other hospitals. Senior staff on duty were informed and the notes were placed in a secure location.
- An audit in 2014 was carried out to see if doctors in the department, seeing patients aged 65 years or over, who were attending A&E with a history of fall were adhering to current A&E guidelines. The results of this audit demonstrated poor documentation. An action plan was put in place to rectify this issue.

Safeguarding

- Processes were in place for the identification and management of adults and children at risk from abuse. Staff understood their responsibilities and were aware of safeguarding policies and procedures. All staff had safeguarding Level 3 training.
- We saw a safeguarding incident relating to an adolescent which was identified by a band 7 nurse. The nurse recognised there was a safeguarding issue immediately and alerted the safeguarding team and the police.
- Paediatric safeguarding pathways were displayed around the department and the safeguarding team checked the records of all children attending the department. All the departments' cards for children were marked with an orange strip for easier identification.
- Three members of staff we spoke with did not know who the safeguarding lead was for the department which may mean that some staff would not know who to go to for safeguarding advice.

Mandatory training

- Data provided by the trust showed nursing staff across all A&E sites completed most mandatory training using e-learning. Compliance with mandatory training for the department was as follows:
- Fire training 76%
- Moving and handling training 95%
- Health and Safety training 64%
- Infection control prevention 85%
- Equality and Diversity 89%
- Safeguarding 77%
- Information governance 63%

For medical staff the figures were much lower and there were aspects of mandatory training that needed to improve.

- Fire training 59%
- Moving and handling training 59%
- Health and Safety training 48%
- Infection control prevention 65%
- Equality and Diversity 61%
- Safeguarding 67%
- Information governance 41%

Assessing and responding to patient risk

- The department did not use the national early warning score (NEWS) records however they used their own EWS scoring sheet.
- As part of our inspection, we looked at the triage process in place within the department. Walk-in patients

were registered at the main reception and asked to wait in the waiting area before being triaged by a nurse. We were told by receptionist staff, if there were any immediate concerns about a walk-in patients' health the receptionist would contact the nursing staff to ask for immediate assistance.

- There was insufficient observation of patients in the waiting room which may result in not detecting a deteriorating patient as soon as possible.
- Systems and processes were in place to receive ambulance pre-alerts for major emergency cases.
- There was no rapid assessment intervention team for patients arriving by ambulance. Rapid assessment and intervention provided early assessment of 'major' patients arriving in the department by senior medical staff.
- However, we saw patients who attended by ambulance were greeted by nursing staff in the middle of the majors area. There was a verbal handover from the ambulance staff to the nursing staff which meant that on the whole, patients arriving by ambulance could be placed in the correct area quickly. However, this was often compromised due to the overcrowding of the department.
- We saw Paediatric Early Warning Scores (PEWS) documentation was available in the department and we observed the paediatric team being called to the department for a feverish child in the resuscitation area. However, adult nurses were not trained to assess children in the triage area which could mean paediatric issues may not be picked up in a timely manner.
- There was a designated phone line to the stroke team. We saw the stroke pathway used where a patient was rapidly triaged by the stroke nurse and referred to a consultant. Treatment commenced within one hour of the patient arriving in the department. The unit also had a remote telemedicine service available to provide 24 hour cover for acute stroke patients out of hours. A consultant specialising in stroke care would be on call.
- Two hourly board rounds had recently been established; this ensured there were no patients at risk. We saw this was predominantly instigated by the nurse coordinating the department and at times this did not happen as the department was too busy.
- Overcrowding in the department was a serious and on-going risk. There was an emergency floor standard operational procedure dated July 2015 which provided a framework for all staff working within the emergency areas. This included roles and responsibilities for all staff both medical and nursing and escalation plans for patients in the department for up to 60 minutes, two hours, 3 hours, 3.5 hours and 4 hours. However there was no guidance on what to do when the department was over crowded.
- There were no trigger factors for the number of patients in the department, the space available in the majors and resuscitation and the number of ambulances queuing. There were also no processes for requesting additional staff and diverting patients to other emergency departments.
- There were also no protocols or risk assessments for caring for patients being looked after in the corridors or in the middle of the department.
- We observed the trauma co-ordinator being called to the department for a patient with a fractured neck of femur so treatment could be commenced immediately and ensured the patent was prepared for surgery as soon as possible.
- We were shown the new paediatric area which had been completed the week prior to our inspection. This area was not open and we were told the area would not be used until the correct paediatric nursing establishment was in place. However, we were told this area had been used as a major's step down area due to overcrowding. This practice was unsafe as this area was not designed to take more seriously ill patients.
- There was no mental health team assessment after 10pm which resulted in a number of patients having to stay overnight on the CDU where they would be looked after by nurses not trained to look after patients with a mental health problem.

Nurse staffing

- There was a total of 49.61 nursing staff in April 2015 (49.61) which was less than the number of staff in April 2014 (51.5). The department had three matrons, seven band 7s (team leaders and one practice development nurse). There were six teams and the band 7 would monitor training, sickness and appraisal.

Urgent and emergency services

- According to information provided to us by the trust, the department had a 9.78% vacancy rate for nursing staff, a turnover of 15.2% and a sickness of an average of 5%. There was also high use of agency nurses which was 21.6%. On the day of our inspection six of the 14 nursing staff on duty were agency staff. The trust spent £200,000 in agency staff in June 2015.
- Although the department did not utilise the 'Safe Staffing Tool', which is a specific acuity tool to determine safe staffing levels. However, nursing shifts were staggered throughout the day to ensure that there were sufficient numbers of nurses available during peak times.
- Staffing levels changed at different times in the day for example: there were 16 registered nurses from 7.30am to 8 pm, 12 nurses from 8pm to 10pm and 10 nurses after 10pm covering the night shift.
- There was not a full paediatric trained workforce in the department. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Settings (2012) states there should always be registered children's nurses in the emergency department. The department had 2.4 whole time equivalents (WTE) trained children's nurses which would not enable the department to ensure a children's nurse was always on duty. We were assured that all nurses were trained in paediatric life skills. The department were aware of this risk and were actively looking to recruit more children's nurses.
- The minor's area was run 7.7 WTEs which equated to one band 7 and two band 6 emergency nurse practitioners (ENPs). There were no ENPs after 8.00pm and the minor's area would be staffed by a technician (band 3) until midnight. The minor's area would then close and all patients would be seen in the major's area. We noted that in the communication log a band 3 reported feeling uncomfortable being on her own in the minors area, she said she felt vulnerable.
- We saw nurses from the minor's area frequently being taken away by doctors to give medicines to patients in the major's area. This affected the continuity of care and slowed the flow of patients through the minor's area. We were told this was a regular occurrence which happened several times a day and was worse in the evening when the majors became full.

Medical staffing

- Consultants cover both sites at the William Harvey Hospital and the Queen Elizabeth Queen Mother Hospital which made it difficult to cover. According to information provided by the trust, the department was experiencing a high consultant vacancy (20.81%) with a turnover of 13% resulting in the department employing a high percentage of locum staff (29.4%) to cover the vacancies. Funding had been agreed to increase the consultant numbers to 20 across the two sites. The trust had a recruitment plan in place and was advertising to recruit to these vacant posts.
- The medical staffing compliment was made up of 55 WTEs, with 16% consultants, 23% middle grade doctors, 27% registrars and 33% junior doctors.
- There was a consultant on duty in the department between 8am and 7pm, Monday to Friday and up to 1pm on Saturday and Sunday when on call.
- On the day of our inspection there was three consultants on duty; one from 8am to 4pm, another 9am to 5 pm and the final consultant 11am to 7pm. There was a shortage of four doctors to cover the 24 hour period. There were four junior doctors and five registrars for the day rota, losing one doctor at 4 pm and another at 6 pm.
- According to the data provided by the trust, the trust spent £2,000,000 last year to pay for locum staff.

Major incident awareness and training

- Due to the closeness of the channel tunnel, M20 and Dungeness nuclear power station, the trusts major incident procedure was being reviewed and training to support the procedures were in place however, there was no major incident training for paediatrics.
- 85% of staff in the department had attended major incident training. There had been no major incident exercise for 18 months.
- There was an incident due to contamination by a chemical material earlier in the year, the department prepared for patients to arrive at the department but it was then decided there was no incident. This gave staff the opportunity to prepare for a chemical incident.

Urgent and emergency services

Are urgent and emergency services effective?

(for example, treatment is effective)

Inadequate

We rated the effectiveness of the department as Inadequate.

Staff were well supported with good access to training, supervision and development. Evidence based guidance was used across a range of conditions but these were often out of date and some staff did not know how to access them.

The department participated in national and local audits about their clinical practice. However, the 2015/16 Clinical Audit Programme for Urgent Care & Long Term Conditions Division highlighted there were a number of audits undertaken by the department where there were no action plans to improve the outcomes for patients.

Some of the college of emergency medicine CEM audits demonstrated outcomes for patients may not be as good as expected. This may mean, improvements identified via the audit process may not result in improvements being made and as such patients may not receive best care.

The pain management policy was in a draft and was being developed in conjunction with the trust's medication policy. Patients in the department did not consistently receive timely pain relief. We saw records where there were incomplete pain scores and evidence of patients waiting over 90 minutes for pain relief.

The notes we reviewed did not show food and drink had been offered to patients who had been in the department for more than two hours and the nurses communication log identified that on one shift patients had not been offered food or fluids for over 10 hours. This meant that people who were vulnerable or who had specific dietary needs would not have been identified.

The department had a practice development nurse who was responsible for planning, coordinating and delivering in house training and there was a programme of competency based training and development for each grade of staff. Staff appraisals took place with 75% of nursing staff receiving their appraisal.

Induction was given to new and agency nurses and to medical staff. All registered nurses were paediatric intensive life support (PILS) trained.

Junior doctors told us they felt well supported by the senior medical staff and received regular training. Education sessions took place every Friday morning for nursing and medical staff.

Patients were being asked for verbal consent to be treated and we heard doctors and nurses explaining the care and treatment they were receiving. We spoke with staff about the Mental Capacity Act 2005 and Deprivation of Liberty Standards (DoLS). Some staff understood the basic principles of the Act and could explain how the principles worked in practice in the department. However, three members of staff we spoke with did not know about DoLS.

Evidence-based care and treatment

- There was a range of care pathways which complied with the National Institute for Health and Care Excellence (NICE) and the College of Emergency Medicine's (CEM) clinical standards for emergency departments.
- Staff could access Sharepoint which was an electronic system to store and access evidence based pathways. Medical and nursing staff told us they would use Sharepoint. However, four members of staff told us it was difficult to use the system and finding it on the trust intranet as problematic as the location often changed. We asked staff to access Sharepoint, two members of staff could not find it on the intranet.
- We also found information on the William Harvey Sharepoint system did not match what was on the Queen Elizabeth Queen Mother A&E department's website.
- The IT system to support access to the pathways often would not work, leading to staff being unable to access pathways used to treat and care for their patients.
- Results from the Trauma Audit Research Network were taken to the monthly Trauma Board Meetings which were also saved onto Sharepoint.

- Care pathways for children were seen on the intranet, some of these were out of date, for example; the management of bronchiolitis. There were some paper copies of resuscitation guidelines in the department but these were out of date.
- The department had a forward plan for auditing its practice such as: care of the patients with a pneumothorax, head injuries and sedation in ED. However, the 2015/16 Clinical Audit Programme for urgent & long term conditions division highlighted there were a number of audits undertaken by the department where there were no action plans to improve the outcomes for patients. This may mean, improvements identified via the audit process may not result in improvements being made and as such patients may not receive best care.
- An audit for upper gastrointestinal bleeds showed documentation could be improved.
- We saw the stroke pathway used where a patient was rapidly triaged by the stroke nurse and referred to a consultant. Treatment commenced within one hour of the patient arriving in the department. The unit also had a remote telemedicine service available to provide 24 hour cover for acute stroke patients out of hours. A consultant specialising in stroke care would be on call.

Pain relief

- Patients in the department did not consistently receive timely pain relief.
- We saw records where there were incomplete pain scores and evidence of patients waiting over 90 minutes for analgesia.
- In the CQCs national A&E survey, 7.7 patients out of 10 said staff did all they could to help control their pain. However, 4.4 patients out of 10 had to a long time for pain relief.
- The department performed poorly in the CEMs fractured neck of femur audit 2012/13. Hip fractures are painful and the administration of pain relief should be a priority in the emergency department. Approximately 42% of patients received adequate pain relief in the 2012/13 audit and was in the lower quartile.
- The pain management policy was in a draft and was being developed in conjunction with the trusts medication policy.

Nutrition and hydration

- The four sets of notes we reviewed did not show food and drink had been offered to patients who had been in the department for more than two hours. This meant that people who were vulnerable or who had specific dietary needs would not have been identified.
- However, in the CQCs national A&E survey, 6.5 out of 10 patients told us they could access suitable food and drink while in the department.
- There was a drinks machine in the waiting area for patients waiting to be seen in the department.

Patient outcomes

- Some of the CEM audits demonstrated outcomes for patients may not be as good as expected, for example: the audit of the severe sepsis and shock 2013-2014 showed a deterioration in the management of sepsis from previous years performance, such as 66% of blood cultures were obtained prior to a patient leaving the department, previous performance was 73%.
- 36% of blood cultures were obtained prior to antibiotic administration with previous performance being 82%.
- However, the management of sepsis was identified on the directorates risk register and plans were in place with actions and timescales to improve the management of this condition.
- The CEMs audit of Initial management of the fitting child clinical audit 2014-15 showed that over half of the children had a blood glucose recorded and were managed in accordance with advanced paediatric life support (APLS) guidelines.
- However, the audit showed that there should be improved compliance with documenting the treatment and a more consistent recording of hypoglycaemia. There was also no consistent provision of information for parents of patients presenting to the emergency department with fits. The department had put plans in place to rectify this.
- We saw nurses from the minor's area frequently being taken away by doctors to give medicines to patients in the major's area. This affected the continuity of care and

slowed the flow of patients through the minor's area. We were told this was a regular occurrence which happened several times a day and was worse in the evening when the majors became full.

- Patients with a mental health problem would be seen in the department but there were often delays in the mental health crisis team reviewing patients.
- In April 2015 the unplanned re-attendance rate to the unit within seven days of discharge was 8.3% which was above the England average of 5%; this may mean patients may not be getting the best possible care at their first attendance.
- Over the last year proximately 250 patients (2.3%) left the department without being seen. This may be due to the long wait to be seen by a doctor in the department and could lead to the patient being more at risk of returning with the same illness.
- We saw a patient with sepsis who did not receive any antibiotics or fluids and had been in the department for over two hours.
- We saw registered children's nurses looking after adult patients in the majors section while children were in the department and on one occasion one child was in the resuscitation area. The children's nurse had not been informed that a child was in the department. Nurses trained to specifically look after children are not trained to look after adult patients. Children's nurses would feel out of their depth to look after adult patients.
- We were also told that children's nurses had been employed in the past but leave due to being asked to provide care for adults when they had not been trained to do so.
- We were told by one member of staff that they would not want their child to be looked after in this department.

Competent staff

- The department had a practice development nurse who was responsible for planning, coordinating and delivering in house training.
- There was a programme of competency based training and development for each grade of staff.
- Induction was given to the new and agency nurses and to medical staff.
- All registered nurses were paediatric intensive life support (PILS) trained.
- Junior doctors told us they felt well supported by the senior medical staff and received regular training. Education sessions took place every Friday morning for nursing and medical staff.
- Staff appraisals took place with 75% of nursing staff receiving their appraisal.
- Band 3/5/6 and 7 were undertaking trauma immediate life support (TILS) training with 84% of staff had been trained to date.

Multidisciplinary working

- We saw the ambulance stroke pathway was working well and patients were fast tracked through the department ensuring the appropriate professionals were involved at the correct time in order to optimise the best patient outcome
- We observed some difficult situations such as where a consultant wanted to refer a nine day old baby to the paediatricians for further care but the referral was refused. This was escalated and resolved but we were told this was a common occurrence.
- We were told meetings with other specialties were improving and there was a more open dialogue to ensure patients were seen as quickly as possible by the most appropriate professional.

Seven-day services

- The department offered a seven day service with senior medical staff present in the department seven days a week.
- There was full 24 hour access to diagnostic and screening tests.
- The integrated discharge team was also available seven days a week to enhance a timelier and appropriate discharge from the trust.
- Physiotherapists were seen in the department assisting patients mobilise and were available from 9am to 5pm, Monday through to Friday.

Access to information

Urgent and emergency services

- Staff were able to access patient information using an electronic system and using paper records.
- Waiting times for other emergency and urgent care departments across the trust were displayed in the patients waiting area. However, we saw that at times this information was not always displayed.
- There were numerous leaflets on display relating to a number of differing conditions for patients to read and take home with them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to be treated and we heard doctors and nurses explaining the care and treatment they were receiving.
- We spoke with staff about the Mental Capacity Act 2005 and deprivation of liberty Standards (DoLS). Some staff understood the basic principles of the Act and could explain how the principles worked in practice in the department. However, three members of staff we spoke with did not know about DoLS.

Are urgent and emergency services caring?

Requires improvement

The rated the care given to patients in the department as requiring improvement.

We saw compassionate care given to children and patients in the minor's area and staff were trying to care for their patients as best as possible but due to the overcrowding and pace of the department it was difficult for staff to spend time with patients.

The CQCs national A&E survey showed that staff explained what was happening and had time to listen to patients. However, we saw patients left on trolleys rather than beds and therefore not receiving relief for pressure areas. We saw patients on trolleys and chairs in the corridor and patients stacked in the middle of the department as there were no bays available. Patients were having cannulas inserted in the corridors and patients were placed on chairs in the major's area.

We saw patients' privacy and dignity being compromised for example; we saw patients being examined in the main corridor and an incident where a patients' private areas were exposed to the public due to the curtains not being fully closed.

Patients with a mental health problem experienced long delays to be seen by the mental health team and there were no dedicated facilities for them to stay in the department whilst waiting to be seen.

Compassionate care

- The results of the CQCs national A&E survey disclosed the majority of patients (8 out of 10) said they had enough privacy and dignity when discussing their health problem with the receptionist. 9.1 patients out of 10 said they were acknowledged by staff and staff did not talk in front of them as if they weren't there. However, 6.7 patients out of 10 felt reassured by staff if they were distressed while in the department.
- The trust scored worse than the England average in the NHS Friends and Family Test for the last 15 months (52%) although this was starting to improve. The unit displayed their results in the staff room but there were no posters showing their results in the waiting room or treatment areas.
- We saw ENPs providing compassionate care to adults and children's in the minor's area.
- However, we saw patients left on trolleys rather than beds and therefore not receiving relief for pressure areas. We saw patients on trolleys and chairs in the corridor and patients stacked in the middle of the department as there were no bays available. Patients were having cannulas inserted in the corridors and patients were placed on chairs in the major's area.
- We saw patients' privacy and dignity being compromised for example; we saw patients being examined in the main corridor and an incident where a patients' private areas were exposed to the public due to the curtains not being fully closed. We had also received a complaint from a patient whose privacy and dignity had been compromised.

Urgent and emergency services

- Patient's medical histories were taken in the main area where the ambulance crews would bring patients into the department for handover to staff. Any member of the public or patient would be able to hear these conversations.
- We saw one lady who was having a miscarriage being moved out of a side room into the main department so a patient with diarrhoea and vomiting could be admitted to the side room. Whilst it was good practice to isolate a patient with diarrhoea more thought should have been given to where the lady should have been placed in order for her to have more privacy.
- We saw a nurse asking patient questions whilst facing the computer with her back to the patient. We saw a child being assessed in the majors cubicles with the curtains open so they were exposed to a distressed adult female in the opposite cubicle.
- One patient was asked to take off her bra under her shirt in the x-ray waiting room in front of other patients.
- We saw the children's nurse communicating with children and parents in a friendly and effective manner. There were examples of good distraction techniques for children. Children waiting to be seen were provided with toys and offered to stay in the family room.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved in their care. In the CQCs national A&E survey: 7.8 patients out of 10 said they were involved as much as they wanted to be in decisions about their care and treatment.
- 8.0 patients out of 10 felt their doctor or nurse explained their condition and treatment in a way they understood and 8.6 patients out of 10 told us they felt the doctor or nurse listened to what they said. 7.4 patients out of 10 said they had enough opportunity to talk to a doctor if they wanted to.
- We observed an incident where a parent brought their sick child into the department. The parent was the primary carer and fully understood the child's long term needs but the medical staff did not listen to the parent and carried out a procedure which could have compromised the child's care. The parent subsequently made a complaint to the trust. Nurses apologised to the parent at the time of the incident and reported the incident to the senior nurse in charge.
- Patients and relatives told us they were looked after well by staff in the department and understood what was happening to them.

Emotional support

- In the CQCs national A&E survey, 7.1 out of 10 patients said the doctor or nurse discussed their anxieties or fears they had about their condition or treatment.
- However, we saw on occasions parents were left with their children feeling very stressed. One mother we spoke with told us she couldn't understand what the doctor was telling her so didn't understand what was happening to her child.
- We observed staff trying to care for their patients as best as possible but due to the overcrowding and pace of the department it was difficult for staff to spend time with patients.
- The CEMs audit of mental health in ED 2014/15 showed that 84% of patents with a mental health condition had a risk assessment taken and recorded in the patient's clinical record and 95% of cases the history of patient's previous mental health issues taken and recorded. However, the mental state examination taken and recorded was carried out in 3% of patients and no patients were assessed by a mental health practitioner within one hour. Also, there was no dedicated assessment room for mental health patients.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated the responsiveness of the department as requiring improvement.

Urgent and emergency services

Trusts in England were tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The department had struggled to meet this target consistently; its lowest performance was in January 2015 at 80.15%.

The management of the department were aware of the increasing demands on the department and were working on introducing new services to manage the demand.

Reconfiguration of the premises was underway to attempt to accommodate the increase in demand and improve the flow of patients through the department.

There was a Clinical Decision Unit (CDU) which took patients from the department when they may be waiting for over 12 hours for a decision to admit for further treatment or to be discharged out of the hospital. This ensured that no patient was left on a trolley in the department for more than 12 hours.

However, a number of patients stayed on the CDU for more than three days and there were times where patients with a mental health condition would stay on the unit whilst waiting for a mental health assessment being looked after by staff with no mental health experience.

Translation/interpreter services were available at the hospital for use when patients whose first language was not English enter the department.

Service planning and delivery to meet the needs of local people

- The management of the department were aware of the increasing demands on the department and were working on introducing new services to manage the demand.
- For example: Triage and medical staff could refer patients directly to the ambulatory care team which helped to reduce the number of patients waiting in the department.
- Emergency department facilities were largely appropriate for the services that were delivered. Reconfiguration of the premises was underway to attempt to accommodate the increase in demand.
- There was a helipad directly opposite the department with quick and easy access to the ambulance entrance.
- We saw at times, the main waiting areas were often overcrowded and could not always cope with the high number of patients waiting to be seen and treated.

Meeting people's individual needs

- Comfort rounds were sporadic and on occasions did not take place for more than 10 hours.
- There was no dedicated waiting area for children and children would be seated next to adults.
- We heard patients asking for a pillow but they were told there were no pillows for patients. We were told by staff not to use pillows as they were being saved for when the CQC visited the department.
- Patients with complex needs may not receive timely care as there was no mental health assessment after 10pm so patients had to stay overnight until seen by the mental health team.
- We saw a 10 month old baby in the parent's room with her parents after sustaining a head injury. The baby had been in the department for 90 minutes waiting to be seen by a paediatrician. The baby had not been seen by a children's nurse at that point. This meant that any deterioration in the baby's condition may not have been picked up in a timely manner.
- We spoke with one senior nurse in the minor's area about how staff looked after patients living with a learning disability. We were told 'we manage as best we can'. There was no designated link for looking after patients with a learning disability.
- Patients with dementia had long waits for a bed. We observed one patient admitted to the department who suffered from dementia. There was no evidence that this was documented in the patients notes We were told by nursing staff there was no special care for this group of patients.

Access and flow

- Trusts in England were tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The department had struggled to meet this target consistently; its lowest performance was in January 2015 at 80.15%.

Urgent and emergency services

- Between April 2014 and March 2015 the department met the four hour wait to be seen 80.5% of the time in the major's area and 98.2% in the minor's area. Data supplied by the trust showed for the month of April 2015 there were 16,466 attendances with 1,759 four hour breeches which equates to 89.3% compliance for majors, with the time to be seen in minors at 92%.
- The CDU took patients from the department when they may be waiting for over 12 hours for a decision to admit for further treatment or to be discharged out of the hospital. This ensured that no patient was left on a trolley in the department for more than 12 hours.
- However, a number of patients stayed on the CDU for more than three days and there were times where patients with a mental health condition would stay on the unit whilst waiting for a mental health assessment being looked after by staff with no mental health experience.
- A four bedded paediatric area had been developed and was waiting to appoint paediatric trained staff before the area could be opened for use. 5.6 children's nurses had been appointed and would be soon coming into post.
- The department had no black breaches. A black breach is when a patient waits more than 60 minutes to be handed over from the ambulance crew to the hospital staff. Between April 2014 and March 2015 a total of 27 patients waited over 30 minutes to be formally handed over to the department.
- However, some patients brought into the department by ambulance waited too long to be handed into the care of the emergency department staff. Ambulance crews told us they often had to wait over an hour to transfer some patients onto a trolley.
- Translation/interpreter services were available at the hospital for use when patients whose first language was not English enter the department.
- There was a daily text relating to the bed state in the hospital which would inform staff about the bed situation. We were told this did not always happen.
- We were told the minor's area was often used for major patients when the major's area was full.
- Whilst we understood there was a trial to determine whether the CDU could work as an acute medical assessment unit to improve the flow of patients through the urgent and emergency care pathway. When we spoke with staff some found it a very complex system as to who could and couldn't be admitted to the CDU.
- Some staff told us 'it was a dumping ground' for patients about to breech the 12 hour wait.

Learning from complaints and concerns

- Between April 2015 and June 2015, 56 complaints were received in the department. The most common cause of complaint was concerns about their clinical treatment.
- Staff we spoke with were familiar with the complaints procedure and felt confident to deal with complaints.
- We were told the matron would review the complaints and identify any trends.

Are urgent and emergency services well-led?

Inadequate

There was no strategy for the emergency department, this was being developed and in draft format. However, the urgent and long term conditions directorate was contributing to the trusts 'Developing our Future' five to ten year strategy. There was a vision for children's services in the department however; there were no plans for shared paediatric rotas and no plans for shared paediatric governance at this time.

Changes were being made to improve the flow of patients through the emergency care pathway. These changes were being tested out at the time of the inspection.

Monthly meetings were held to review incidents, complaints, progress on audit activity and other safety issues. This was attended by senior clinicians and managers.

The divisional risk register detailed the risks associated with poor patient flow, increased activity, delays in the department and staffing levels. These risks mirrored what staff and managers told us.

Urgent and emergency services

The directorate team were aware of the challenges the department faced and there was a senior managerial presence in the department. However, there was no visual clinical leadership on the major's floor which resulted in an impression of chaos and disorganisation.

In CQCs report from 2014 the lack of visible leadership was highlighted as a concern. It would appear the directorate team had actioned this by having a shift coordinator role: a major's coordinator role and a matron.

However whilst there was visibility the three roles did not seem to work well together. This meant there were now three 3 nurses all supernumerary (the matron, the department coordinator and the majors coordinator) with no single person giving leadership, direction and supervision to the rest of the team.

There appeared to be a duplication of roles where there were now three senior roles coordinating the department which in itself causes blurring of the role boundaries. What appeared lacking was hands on visible leadership within the major's area, in particular the high use of agency staff created the need for strong clinical supervision and leadership to ensure the safety of those patients being cared for.

Patients were not seen in a reliable way and nobody seemed to know overall what the patient state was. We observed good leadership in the minor's area although we were told this was sometimes hampered by senior manager's interaction and interruption.

We found staff morale was improving since the last CQC inspection. However, there was a culture of acceptance where staff came to believe there was no point in escalating overcrowding as this was a daily occurrence. We asked six members of staff at what point would they escalate unsafe occupancy levels, they told us there was no limit to the number of patients that were in attendance so they would not report the levels.

Vision and strategy for this service

- There was no strategy for the emergency department. This was being developed and in draft format. However, the urgent and long term conditions directorate was contributing to the trusts 'Developing our Future' five to ten year strategy.
- A policy for managing how children should be treated was being drafted but at the time of the inspection there was no policy or guidance about how children should be assessed and treated.
- Changes were being made to improve the flow of patients through the emergency care pathway. The urgent and long term conditions directorate were piloting a new model of care in the CDU by moving to a dedicated acute medical unit. This would be run by acute care physicians providing 'hot care' to patients coming through the unit either via a GP or the ED. The intention was to avoid admissions to the hospital, facilitate early discharges and improve the flow of patents through the department.
- An external review had taken place to examine the issues affecting operational effectiveness and patient flow. The emergency care intensive support team (ECIST) had visited in May 2015. Its recommendations focused on demand and capacity pressures in the department, caring for children and young people in the department, staff awareness of the trusts Incident response plan in the department and staffing levels both medical and nursing. Recommendations had been incorporated into the trusts special measures action plan and progress against milestones was monitored on a weekly basis.
- There was a vision for children's services in the emergency department however; there were no plans for shared paediatric rotas and no plans for shared paediatric governance at this time.
- New roles were being explored such as the use of paramedic technicians and introducing band 4 paediatric roles to increase nurse staffing levels.

Governance, risk management and quality measurement

- Monthly meetings were held to review incidents, complaints, progress on audit activity and other safety issues. This was attended by senior clinicians and managers.
- There were 12 risks on the divisions risk register. The detailed the risks associated with poor patient flow, increased activity, delays and staffing levels within the department. Other risks included the lack of policy and guidance for managing children when they attend the

department and the effective management patients with sepsis. These risks mirrored what staff and managers told us. There were actions to address these risks with dates attached for completion.

- The way in which concerns/ incidents were reported led to an under reporting of incidents as staff used an informal process for raising issues (communication log) which should have been categorised as an incident. We crossed checked the daily communication log with the clinical incidents that had been reported via datix. There were a number of concerns raised via the communication log that should have been datixed. For example: patients not having a drink or something to eat for over 10 hours, no comfort rounds and patients not receiving pain control for over two hours.
- The department's escalation policy was described by staff as being 'elderly'. Staff did not use the policy to alert senior staff to the capacity issues on a daily basis.

Leadership of service

- The directorate team were aware of the challenges the department faced and there was a senior managerial presence in department. In CQCs report from 2014 the lack of visible leadership was highlighted as a concern. It would appear the directorate team had actioned this by having a shift coordinator role: a major's coordinator role and a matron.
- However whilst there was visibility the three roles did not seem to work well together. This meant there were now three 3 nurses all supernumerary (the matron, the department coordinator and the majors coordinator) with no single person giving leadership, direction and supervision to the rest of the team.
- There appeared to be a duplication of roles where there were now three senior roles coordinating the department which in itself causes blurring of the role boundaries. What appeared lacking was hands on visible leadership within the major's area, in particular the high use of agency staff created the need for strong clinical supervision and leadership to ensure the safety of those patients being cared for.
- However, the site manager had to micro manage the department to make up for the lack of nursing leadership. It was documented through the nurses communication log this wasn't always helpful and clinical decisions could not always be made due to having to respond to performance queries from the management team.
- We saw a band 5 nurse in charge of the majors with no supervision from more senior staff. Matrons did not support staff operationally as the operations senior manager picked up what was happening across the department. By putting the band 5 as major's co-ordinator created the need for supervision by the department co-ordinator which is not possible at all times.
- Board rounds had been instigated recently. This was two hourly meetings with medical and nursing staff to discuss all the patients in the department and to ensure no patient was at risk.
- There was ineffective shift coordination and escalation relating to overcrowding. There was no visible leadership from the matrons. At busy times we very rarely saw a matron in the department. We did not see the matron going into the department and talking to patients nor supporting junior staff that were providing care to patients.
- When the department was extremely busy we saw no visual medical leadership and there was an absence of joint working with the consultant and nurse lead in the department.
- Services for children in the department were generally poor for children. Senior operational medical and nursing staff did not know how many children were seen in the department. This would mean services for children may not be safe and effective as there was no forward planning to care for these children.
- Registered children's nurses were looking after adult patients in the major's area whilst there were children being treated in the department. There was no mechanism to alert the children's nurse when a child was in the department. On two occasions we had to inform senior staff that a child was in the department to ensure the child was cared for by the children's nurse.
- We observed good leadership in the minor's area although we were told this was sometimes hampered by senior manager's interaction and interruption.

Culture within the service

- Staff told us morale was good and had improved since the last CQC inspection. We were told staff were more optimistic about the changes in the future.
- There was a culture of acceptance where staff came to believe there was no point in escalating overcrowding as this was a daily occurrence. We asked six members of staff at what point would they escalate unsafe occupancy levels, they told us there was no limit to the number of patients that were in attendance so they would not report the levels.

Public and staff engagement

- The department used the Friends and Family Test to capture patients' feedback and comments cards were handed out to patients as they arrived in the department. However, posters demonstrating their performance were not displayed in patient waiting areas.
- For the staff A&E survey the department scored 75% for the question 'How likely are you to recommend this organisation to friends and family if they needed care or treatment' and 52% for 'How likely are you to recommend this organisation to friends and family as a place to work'.

Innovation, improvement and sustainability

- The urgent and long term conditions senior team had recognised improvements were needed to address overcrowding and the management of patients flow through the emergency and urgent care pathway and new programmes of work were being piloted.
- There was a designated phone line to the stroke team. We saw the stroke pathway used where a patient was rapidly triaged by the stroke nurse and referred to a consultant. Treatment commenced within one hour of the patient arriving in the department. The unit also had a remote telemedicine service available to provide 24 hour cover for acute stroke patients out of hours. A consultant specialising in stroke care would be on call.

Medical care (including older people's care)

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

Information about the service

Medical care services at The William Harvey Hospital were managed by the Division of Urgent Care and Long Term Conditions. The division also managed the discharge lounge and the Clinical Decisions Unit. There are 12 medical inpatient wards, 166 inpatient beds. These included acute medical units, general medical wards, care of older people, endoscopy services, stroke and cardiac services. The hospital provides primary percutaneous coronary angioplasty (urgent treatment for heart attacks) and thrombolysis (urgent treatment for strokes).

In the period July 2013/14, the last for which figures were available, the trust admitted 7,970 patients to medical care services. At the William Harvey hospital there were 2,590 admissions in the same period. Of these 54% were emergency admissions, 42% day case and 4% elective. General medicine was the speciality for the majority of admissions at 46%. Admissions to geriatric medicine accounted for 19%.

To help us understand and judge the quality of care in medical care services at The William Harvey Hospital we used a variety of methods to gather evidence. We received comments from our listening event and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust and the hospital. We spoke with nine doctors including seven consultants, about 36 registered nurses including ward matrons, ward managers, specialist nurses and five healthcare assistants. We also spoke with about seven allied health professionals and 10 other support staff. We also spoke with about 27 patients and about five relatives and carers. We interviewed members of the divisional management team. We observed care and the environment, and looked at records, including patient care records. We looked at a wide range of documents, including audit results, action plans, policies, and management information reports.

Medical care (including older people's care)

Summary of findings

Overall, we found medical care services at The William Harvey Hospital required improvement in some aspects of patient safety. This is because we identified some concerns in relation to medical staffing, nursing staffing, especially at night, the storage and management of medicines, the management of confidential records and shortfalls in infection control procedures. Otherwise, we found that there were good systems to report and investigate safety incidents.

We found that treatment generally followed current guidance, but care assessments did not always consider or record the full range of people's needs and were not reflected in plans to individually address their care. We found that there were arrangements to ensure that staff were competent and confident to look after patients. However, medical staff were not always able to access adequate educational support to promote their professional development. Patients were cared for by a multi-disciplinary team working in a co-ordinated way and generally had access to some services seven days a week. However, services such as speech and language therapy and physiotherapy services were not available at weekends. Patients received adequate food and drink and were supported to eat and drink. Consent was obtained and recorded in line with relevant guidance and legislation and where patients lacked capacity to make decisions for themselves, staff acted in accordance with their obligations under the Mental Capacity Act 2005.

We judged the caring aspects of medical care services were good. Patients and their relatives were positive about their experience of care and the kindness afforded them. They told us they received a high standard of care that met their needs. We observed compassionate care that promoted patients' privacy and dignity. Patients were involved in their care and treatment and were given the right amount of information to support their decision making and patients could get the emotional support they needed.

We judged that the responsiveness of medical care services required improvement. This was because there was insufficient bed capacity to meet the needs of patients. This resulted in almost half patients being moved at least once during their hospital stay. There were large numbers of patients in non-speciality beds and this had negative implications for their safe care and treatment. We also found that support for people with mental health needs was variable and the discharge of patients was not managed in a timely manner, especially at weekends.

We judged that Well Led was good. There was an appropriate system of governance in medical care services and arrangements to monitor performance, quality and risk in which concerns were escalated to the trust board and key messages disseminated to staff. Staff acknowledged the steps that had been taken within the organisation to improve structures, processes and systems of accountability. They could discuss the trust philosophy and individual wards developed their own strategies which staff understood. We observed a caring and positive ethos. Staff acknowledged developments to embed a more cohesive culture of openness between senior managers and staff but reported that although the culture was improving, they did not always feel actively empowered or engaged. They felt improvement was reactive and focussed on short term issues.

There were examples of collaborative working with the voluntary sector and where patient representatives had been involved in developing and monitoring services.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Overall we found medical care services at The William Harvey Hospital required improvement in some aspects of patient safety.

This was because we found that there were insufficient doctors and registered nurses on duty, particularly at night, to meet the needs of patients. There were insufficient systems to ensure that resuscitation equipment was maintained ready for use. Medicines, including controlled drugs, were not always stored safely according to The Misuse of Drugs Regulations 2001 and The Nursing and Midwifery Council's "Standards for Medicines Management." There was inconsistency in the quality of record keeping and confidential patient records were not always kept securely.

There was a positive culture of incident reporting. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and were supported when they did so. There were robust arrangements for investigating safety incidents and monitoring the implementation of action points following an incident. A range of suitable forums for staff to receive feedback and learning had been established. Rates of harm free care as monitored by the national Safety Thermometer programme show a harm free care rate of 94.3% which is slightly above the England average of 94%.

We found that measures for the prevention and control of infection met national guidance, but systems for providing assurance around cleaning and hand washing were not always followed. The clinical environment appeared clean but on some wards shower and bathroom facilities were not sufficient or maintained appropriately to meet patients' needs. There was sufficient equipment that was properly checked and maintained to meet patients' needs and staff were competent to use it. Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances and acted according to local policies when abuse was suspected. Mandatory training in 2014 helped ensure nearly all staff had current knowledge and skills in key safety areas.

Incidents

- Trust policy stated that incidents should be reported through a commercial software system enabling incident reports to be submitted from wards and departments. All staff we spoke with across medical care services at The William Harvey Hospital told us there was an evolving culture of encouraging the reporting of incidents. They knew how to use the system and were confident in demonstrating its use to us.
- There were no "Never Events" reported in medical care services in the period May 20014 to April, 2015. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Medical care services reported 20 serious incidents between May 2014 and April 2015, out of 24 across the trust. This represented 83% of all incidents. Of the incidents in medical care services 60% were in general medicine and 20% were in geriatric medicine. This correlates with the areas of most admissions. The most common serious incident reported was pressure ulcers grade three and four, (10) and slips trips and falls (7).
- At William Harvey hospital between January and April 2015 there was one severe incident reported and 76 of moderate harm. There were also 550 low and no harm incidents reported which indicates a good reporting culture within the organisation.
- There were 69 incidents resulting in delay in providing treatment during May. Two incidents were graded as death and have both been reported on STEIS; none were graded as severe harm. Four have been graded as moderate harm and are currently under investigation, 24 have been graded as low harm and 39 resulted in no harm. Themes in this location were: five incidents occurred in Celia Blakey unit, four in A&E, three each in Ambulatory Care and on the waiting list.
- We found that a root cause analysis (RCA) was conducted for serious incidents. We saw good examples where the root cause was identified and that the resultant action plan reflected this.
- Training in RCA techniques was provided for 43 members of staff at The William Harvey Hospital. This included matrons, or managers from medical care services who have a lead role in patient care and management.
- We looked at a selection of minutes for ward and matrons' meetings held during May and June 2015, and

subsequent divisional governance meetings. These demonstrated that safety incidents and the outcomes of their investigations were standing agenda items and that the data was used to monitor performance, track risk trends and cascade learning back to teams.

- Staff told us that there was learning from incidents, which resulted in change of practice and gave us examples of how this had occurred at local level. An example was the increased use of pressure mats and non-slip slippers identified for those patients at a high risk of falls. This showed there was feedback and learning from critical incidents and reflected the trust's reduction in reported falls.
- Staff reported that the trust promoted and encouraged a culture of reporting incidents to drive improvement. They spoke positively on how the recent appointment of a new clinical governance manager had resulted in an increased awareness of incidents and themes both throughout the trust and within the hospital.
- We saw examples of the "Risk Wise" pamphlet that was circulated by the trust on a quarterly basis. Staff described how this had significantly increased awareness of incidents and associated change of practice within the wider organisation community as opposed to just their own areas of responsibility.
- Morbidity and Mortality meetings were held as a trust-wide forum. We saw minutes that showed medical care services were involved in these meetings and that the care of medical patients was reviewed. Individual trends were identified, managed and actions taken including disseminating lessons learned. Our monitoring showed that there were no mortality indicators which demonstrated a risk of increased mortality. The indicators showed that the trust was performing better than expected against comparable hospitals.

Duty of Candour

- The trust reported that 43 members of staff had currently undertaken duty of candour training as part of their RCA training. We asked staff about their understanding of the new regulations concerning duty of candour. Most were able to describe the concept and understood the organisation's responsibility for transparency and openness. However, we were told that not all had received training in the regulations or fully understood the statutory process to be followed. When we reviewed the RCA process we saw that there were clear prompts included to ensure that the process was followed.

Safety thermometer

- The medical care services at East Kent Hospitals University Foundation Trust participated in the national safety thermometer scheme. The NHS Safety Thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections. Ward managers collected monthly data as part of the scheme. Key safety information such as days since the last fall, incidence of pressure damage or avoidable infection was displayed at the majority of ward entrances in a format that was easily understandable to patients and their families. When we asked about the actions that had been taken to improve, we were shown examples of initiatives that had been introduced to reduce patients' risk of falls.
- The safety thermometer point prevalence audits between December 2013 and December 2014 which was the most up to date information available identified 54 new pressure ulcers, 100 cases of urinary tract infections (UTI's in patients with a catheter) and 35 cases of harmful falls which occurred within 72 hours.
- Hospital acquired harms (new harms) are now significantly lower than the national average. Current information reports that the trust was achieving 1.7% against a national average of 2.4%.
- A lower than average harm rate for new pressure ulcers and falls with harm has been achieved and rate of new VTEs in line with the national average.
- Urinary tract infections in patients with a urinary catheter has increased slightly above the national average but has reduced from the national average in 2013/14. We saw the organisation had implemented a guide (HOUDINI) for staff to help staff in the assessment of the appropriateness of a urinary catheter remaining in place. We saw this guide publicised but found little evidence of its use on the wards.
- All wards used safety crosses displayed on the wall for each month, and these were visible to patients, visitors

and staff on the wards. These showed the number of falls, pressure ulcers and infections such as MRSA and C. difficile that had occurred during the month and on what date. The results were fed into the safety thermometer and ward to board assurance framework, which in turn contributed to the trust data. We saw the results of these were monitored by ward by managers and matrons.

- Safety thermometer data was incorporated into the divisional performance dashboard which was used to provide evidence of assurance to the trust board. In May 2015 the William Harvey Hospital achieved over 94.3% for harm free care which is slightly above the England average of 94%.
- The trust reported that the rate of falls per 1000 patient bed days was 5.37 which places the trust below the England average of 5.4.
- Of the 150 patient falls recorded for the trust in May 2015 (163 in April 2015), four incidents were graded as moderate, no incidents were graded as severe or death. There were 81 falls resulting in no injury and 65 in low harm. The top reporting wards at The William Harvey Hospital were Cambridge M2 with nine falls; CDU with eight falls and Cambridge M1 with seven falls.

Cleanliness, infection control and hygiene

- Overall, we found that the Department of Health's "Code of Practice on the prevention and control of infections and related guidance" was complied with in medical care services.
- Clostridium difficile (C Diff) and Meticillin-resistant staphylococcus aureas (MRSA) for the trust were within expected statistical limits and below the organisation's targets.
- Throughout our visit we generally found the wards and specialist medical care areas were clean and tidy. We saw support staff cleaning the department throughout the day and doing this in a methodical and unobtrusive way.
- There was a visual guide to indicate which group was responsible for cleaning equipment. We saw this displayed on some wards. However, there was no evidence of cleaning checklists in patient toilets or bathrooms.
- Most of the equipment we examined such as commodes, vital sign monitors, wheelchairs, toilet rising seats were visibly clean but the evidence of a standard green label to indicate it had been cleaned was not universally used. Supplies of these labels were seen on the wards but consistently not completed. Ward managers told us that it was trust policy to use this system to indicate that equipment shared between patients were easily identifiable as ready for use. When we spoke to staff they told us they were aware of the system. We asked staff on the wards that we visited how they were assured that cleaning had taken place. We were told by one ward manager they had seen cleaning staff doing it that morning but agreed that unless this had been witnessed it would be difficult to be assured. This meant that there was no robust assurance process in place to demonstrate equipment was clean and safe to use.
- We saw that single patient use equipment, such as hoist slings were used, and that most clinical equipment was single use only.
- The trust operated an infection control score card giving performance against a range of infection control indicators, including hand hygiene compliance and adherence to the high impact interventions known to reduce infections and cleanliness audits. The wards had large display boards with key infection prevention and control messages and the performance score card for their ward.
- Adequate hand washing facilities and hand gel were available for use at the entrance to the wards/clinical areas and within the wards. There was prominent signage reminding people of the importance of hand washing at the entrances to wards and within the toilet and bathroom areas. We observed that staff generally washed their hands in line with the World Health Organisations guidance "Five moments of Hand Hygiene." However, we saw instances on two wards where student nursing staff did not observe this practice and used gloves without washing hands before or after. We saw that there were monthly audits of hand hygiene and that the results were publically displayed in ward areas. In areas where low compliance were reported, weekly audits had been introduced and were seen to be actively monitored by the Infection control team.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. All staff adhered to the "bare below the elbows" guidance in the clinical areas.

- Side rooms were used to care for patients where a potential infection risk was identified. This could be to protect other patients from the risk or the spread of infection, or to protect patients from infection where they had compromised immunity to infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room. On Oxford ward which was used for patients requiring isolation from all areas of the hospital we saw that the door was propped open, compromising the spread of infection and obscuring the isolation notification.
- We saw that clinical and domestic waste was appropriately segregated and that there were arrangements for the separation and handling of high risk used linen. We observed that staff complied with these arrangements.
- We observed that sharps management generally complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that sharps containers were used appropriately and that they were dated and signed when brought into use. However, we found that in the majority of clinical areas they were not closed appropriately following use.
- Infection Prevention and Control training formed part of the mandatory training programme that was updated yearly. In the first quarter of 2015 the training rates were acute medicine 74.4%, cancer/clinical haematology and haematology 88.2%, Health Care of Older People **(**HCOOP) 69.9%, renal 93.4%, speciality medicines 88.1%. With the trust target of 85% indications were that this programme of training would ensure most people had completed training by year-end.
- We saw that there were effective decontamination procedures for cleaning endoscopes after use and we saw there were supporting audits to maintain standards.
- The trust had a dedicated infection control lead and hospital based infection control teams with link nurse support across all departments. Staff reported that these teams were pro-active across the wards and provided unlimited support. We spoke with a link nurse who confirmed that they were supported to attend developmental training and specialist advice was readily available from the infection control team.
- We saw on some wards that action plans developed to address issues identified in the trust annual infection control audit were displayed. On other wards this information was held in the ward manager's office. It was unclear from the action plans if the actions had been met or were still work in progress. There was no clear review or update information.
- Patients that we spoke with were generally complimentary about the cleanliness of the hospital and told us that cleaning staff "worked hard" to keep the hospital clean.

Environment and equipment

- All the areas we visited during the inspection were clean and tidy. Some wards by nature of their layout presented challenges regarding limited storage space. We saw that staff had been vigilant in reducing clutter in the ward corridors, thereby avoiding trip hazards to keep people safe. However, we found that some bathrooms and showers were used to store equipment which meant that the facilities were not always ready for patients to use.
- We found that each clinical area had resuscitation equipment stored on resuscitation trolleys readily available and located in a central position. The trust policy identified the systems to ensure it was checked daily, fully stocked and ready for use. Daily checks should be recorded. We checked trolleys on all clinical areas that we visited and found that there were omissions on the majority of records. We identified that the main omissions occurred at weekends and the ward managers told us this was often due to staffing shortages or agency staff not knowing who was responsible for the checks. On Cambridge M2 ward we found that records stated that on the 13th July, 2015 the defibrillator had been checked but the automatic check had failed. The machine had recommended a manual check but it was unclear if this had been done as the record was incomplete. Staff were unable to confirm what action had been taken or if this equipment was working and ready for use.
- We were told that the trust resuscitation officer undertook monthly audits of resuscitation equipment, but staff were unclear of what actions were required or had been taken as feedback from the audits was not made available to them. This meant that learning from audits was not communicated and it was not clear if the resuscitation equipment was complete and ready for use in the event of an emergency.

- We found documentation to support that the majority of equipment for example, hoists, slings and the clinical monitoring system had been tested and were maintained to the appropriate standard across the medical division.
- The trust had recently established an equipment library and throughout our inspection, staff were complimentary about this service and the support they received when requesting equipment. The equipment library was open Monday to Friday 9.00 a.m. to 5.00 p.m., with out of hours service available. Staff described that out of hours requests took longer as porters were required to deliver items to wards, but the service was generally reliable.
- Staff told us that Electrical Medical Equipment (EME) was well maintained centrally by the EME department. They said that it was very unusual for them not to be unable to access equipment when it was needed. We saw that all EME had a registration label affixed which meant that the department were aware of its existence and that it was maintained and serviced in accordance with manufacturer's recommendations. We also saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that it had been inspected and was safe to use.
- The trust scored above the England average for Patient Led Assessments of Care in the sections of cleanliness with a range of 86.72% - 99.30%.
- We spoke with staff who explained the systems they followed when they encountered environmental problems or maintenance issues. They described the system and reported that generally it worked well with more minor issues, but bigger issues often remained unresolved. For example in the endoscopy department we found that staff were still encountering leaks in the ceiling which was still under warranty. We saw that this had been reported several times in the last few months but had not been repaired.
- We found that on Cambridge M2 ward there were 20 patients of mixed sex sharing one shower room which was badly in need of refurbishment. The fabric of the shower room was in very poor condition. There were exposed fittings where fixtures had fallen off the wall and cracked badly stained linoleum on the floor and walls. Cleaning staff stated that this made it difficult to clean and maintain safe and hygienic standards for patients to use. Staff showed us that this issue was identified on the ward risk register, had been escalated through the infection control committee by matrons and had been awaiting funding for repair for over a year.
- We looked at fire-fighting equipment throughout the wards and medical speciality units. We noted there was a system of fire risk assessments and equipment displayed labels confirming that it had been maintained and tested. Records were available to demonstrate that an average of 80% of staff in medical care services had completed training in both health and safety and fire safety training.

Medicines

- We found that in the majority of areas, medicines were stored securely in locked cupboards, rooms and medicine trolleys and that keys to drug cupboards were held by appropriate staff. However, on two wards we found medicine cupboards left unattended and open. We consistently found intravenous fluids stored in rooms that were unlocked at the time of the inspection on CDU and throughout the medical wards. This presented a risk of unauthorised access to medicines.
- We saw that medicines were stored in dedicated medicines fridges when applicable. Records were available to us showing that daily checks were undertaken using the fridges built-in digital thermometer. The pharmacy department carried out a check three monthly using the fridges built-in digital thermometer to ensure the temperatures had remained within range. Remedial actions were recorded when temperatures were outside this range.
- We looked at controlled drugs (medicines liable to be misused and requiring special management) in CDU and noticed that the secure 'inner cupboard' was unlocked. Medicine to take away (TTA) packs were also stored in this cupboard. We checked order records, and CD registers and found these to be in order. We spot-checked some medicines and found that stock balances were correct. We saw ward staff to checked stock balances of CDs daily. When we looked at individual records in four medical wards we saw many entries were missing witness signatures. There was also poor recording of patients' own CDs on two wards. This meant that controlled drugs (CD) were not always securely stored and administered according to current guidance and legislation

- CDU and the medical wards had designated pharmacists who visited the wards once or twice a day and checked the medicines charts to ensure that there was safe prescribing and that medicines were prepared for patients discharge. Patients' prescriptions were checked by a pharmacist to ensure their medicines treatment were safe, effective and met current guidance. Clinical staff could access a pharmacist for advice when needed. We saw pharmacy technicians and pharmacists on the wards during our visit. Pharmacy staff told us that there were still insufficient staff to cover the ward areas across the hospital.
- Patients own drugs were kept in a 'green bag' and stored in bedside lockers to ensure that they were not mislaid or mixed with other patients medicines. We saw on CDU that drawers were not locked. On ward M1 we saw a green bag on a window ledge and on M2 they were locked in the patient's locker. This meant that not all medicines were being stored safely.
- We observed that medicines were administered by appropriately trained staff following the Nursing and Midwifery Council's "Standards for Medicines Management." Nursing staff were aware of the policies on the administration of controlled drugs.
- We saw there were adequate resources such as up to date British National Formularies and IV treatment guide that staff could reference when they needed to.
- Nurses completed a training and competency assessment prior to administering medicines without supervision. However, the increased use of temporary staff and a high percentage of newly qualified nurses limited the number of staff able to administer medicines on some shifts on some wards. Staff said this created additional pressure on the staff that were competent to administer medicines.
- We observed medicines rounds in progress and saw staff checked the identity of patients prior to administering their medicines. We observed them talking to patients about how they liked to take their medicines during administration. Patients told us that pharmacy staff were happy to answer questions regarding their medication but sometimes did not like to ask as staff were always very busy.
- We heard that pharmacy was part of an improvement plan to improve the discharge of patents and CDU was proactive in early transition for moving patients to the discharge lounge. We visited the discharge lounge and heard that patients frequently waited several hours for their medicines. One patient discharged from M2 had been waiting from 9.30 a.m. until 2 p.m. for their medicines. The discharge lounge took patients from all over the hospital and although nurses had access to the TTA tracking system they told us they were frequently chasing TTA's to facilitate people's discharge. They told us that this meant they were diverted from providing care and assistance to patients in the discharge lounge.
- There were no safe storage facilities for medicines in the discharge lounge and staff told us they were concerned that on occasions filing cabinets were inappropriately used to store medications when discharges had been delayed. There were no facilities for storing medications that required refrigeration.
- Each medical ward had a technician to top up supplies of medicines so stocks did not run out. There was also a supply of 'take home packs' of medicines in CDU so that patients could be discharged without delay if this was appropriate. Staff in CDU said that other wards in the hospital frequently borrowed stocks of medicines at the weekend and evenings when the pharmacy was closed. We saw documentation to support that these loans were logged.
- Medical and nursing staff throughout the medical division reported that there were shortages of pharmacy staff and simply not enough to cover the wards. On wards M1 and M2 we heard that there were significant delays in obtaining TTA medications for patients. A wait of six to eight hours was not unusual during the working week and weekends were described as, "a nightmare". Medical staff on the gastroenterology ward reported that the lack of ward pharmacist cover meant approximately two to three times per week drug charts had to be sent to the pharmacy. This resulted in problems when patients became unwell or needed pain relief.
- There was a medicines safety group within the clinical governance structure. This group monitored the medicines risk register and when medicine safety issues were identified. Communication was sent to the relevant areas in the form of alerts and emails which was instrumental in raising awareness and ensuring key messages were received. We saw from minutes of meetings that all pharmacy related incidents were reported and reviewed at the Pharmacy Senior Governance Team meeting.

Records

Medical care (including older people's care)

- Medical care services had integrated patient records shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in a patient's care could see their full record. We looked at six medical and 18 sets of nursing records and found that although these were generally compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses, many of the records were disorganised and difficult to navigate. It was evident there was no procedure for maintaining patient records to a uniform trust standard with wards and departments adopting different formats.
- Patients' records were readily accessible to those who needed them.
- We saw that medical records were not always stored securely and that unauthorised access was possible. Records were generally stored in open notes trolleys, in pigeon holes or on shelves in ward areas to which the public had access. Staff told us this was normal practice. On Cambridge M2 we saw records left unattended in the corridor. This demonstrates that confidential patient records were not always kept securely.
- We found many examples of patient notes that were not consistently completed. For example we saw nursing assessments, repositioning charts, food charts and personal care round records were not completed on every occasion. On Cambridge L we looked at six sets of records and found that no nursing assessments had been completed. Some forms had been badly photocopied and were difficult to read.
- We saw that patients were risk assessed in key safety areas using national validated tools. For example we saw that patients were assessed using the Waterlow score which identified when there was an escalated risk of falls and pressure damage. We noted that when risks were identified they were recorded but a supporting care plan was not always in place to highlight the control measures and inform staff of the individual care required by the patient. On Cambridge M1 we found a patient with a moisture lesion, which is caused when skin is exposed to increased levels of moisture, had an incomplete risk assessment, with no grading or supporting care plan.
- We saw that a nationally recognised quality tool for the recording of information known as Situation, Background, Assessment, Recommendation (SBAR) was being used. The information is used to assist in the safe transfer of patients; ensuring specific information is available in a set format. When we checked records we saw that SBARs had not always been fully completed for patients. This meant that staff receiving the patient might have to make additional enquiries about the patient in order to ensure appropriate care was given and the benefits of this system were not fully realised.
- An average of 61% of staff across the medical division had received information governance training.
- Other records we requested in ward areas, such as duty rotas and safety information that were relevant to the running of the service could usually be produced without delay either in paper or electronic formats.
- Appropriate arrangements were in place for the management of confidential waste.

Safeguarding

- The Adult Safeguarding team had been renamed the "People At Risk Team"(PART). We heard how they supported doctors, therapists and matrons across each of the three main hospital sites in all matters relating to safeguarding and the protection of people's human rights. We heard that they worked closely with the specialist dementia, nutrition and tissue viability teams to improve the quality of care for patients.
- A Harm Prevention Group had been established with clinical specialist members to identify and target key clinical issues highlighted in investigations, complaints and local intelligence that affect safeguarding. This new group was a multi-agency trust-wide PART group.
- Safeguarding information, including contact numbers and the trust lead were kept on the wards and staff were aware of how to access this.
- Staff had access to an adult safeguarding policy and the PART team were available to provide advice and guidance, when required. Staff reported that this team were very supportive in giving advice and assisting staff when concerns were raised or information was required.
- Safeguarding training was mandatory for staff and different levels of training were provided according to the job role. The training records indicated that an average of 74% of staff had attended safeguarding training on the medical directorate. This was worse than the trust target of 85% but following this trajectory would ensure most people had completed training by year-end. There was no evidence to support that staff in medical services had received specific training in safeguarding adults.

- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were given examples of concerns they had identified and referrals made. Staff told us that they generally received feedback on the outcome of referrals. An example was given relating to an incident in CDU with the steps taken during the care of a vulnerable patient used as a learning example at a ward meeting. This was further developed for use as part of a study day exercise for other staff.
- Generally patients we spoke with told us they felt safe in the hospital. However, one patient told us that they felt vulnerable when the cleaning staff spoke in their own language and they could not understand what was being said around them.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake.
- The mandatory training programme covered awareness sessions in areas such as fire, manual handling, infection control, falls preventions, safeguarding and life support.
- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed, when it was due.
- All mandatory training for staff was provided through electronic learning but some staff reported they had difficulty accessing the training due to incompatibility of the IT system. The introduction of a new training application had been made available via an icon on each desktop computer and we asked a nurse to give us a practical demonstration of using the system. We saw how the systems was accessed, how training was recorded and staff told us they were supported by senior staff to undertake training.Two members of staff who had experienced difficulty accessing the e-learning told us they had been given support with temporary logins by the IT department. Drop in e-learning clinics were available for staff who wished to complete their training with face to face support.
- Staff described a comprehensive induction process and one new nurse in the endoscopy department said that they found the trust induction "extremely good" and was appointed a mentor who had supported them through their mandatory training. We found that on the majority of wards there were orientation guides for agency staff.
- Compliance with mandatory training over all for the medical division was 62.9 % for Doctors, 79.8% for nursing staff and 87.% for allied health professionals against the trust target of 85%.

Assessing and responding to patient risk

- We found that patients physiological parameters such as pulse and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' We watched observations being taken and noted that the technique used would ensure an accurate result.
- There was an electronic system to record patients' physiological observations; this is known as a national early warning score (NEWS) system. We saw that where NEWS scores indicated patients may be deteriorating nurses had mostly requested medical reviews. Patient observations were recorded electronically using a hand held device which automatically calculated early warning scores. We saw a demonstration of this equipment which indicated when observations were required and what the current NEWS scores for patients were. This was accessible on all wards. Nursing staff reported that generally the use of this system across the medical wards and medical specialities was used to prompt nursing staff to contact medical staff. The facility to bleep medical staff was reported as being intermittently effective, due to the availability of units and unreliable communication networks.
- There were arrangements for staff to access a critical care outreach team to support and advise in the care of very sick or deteriorating patients. Ward staff had access to the site matron team. The night staff especially felt the support these matrons provided was valuable and helped in the provision of safe care.
- We saw that patients were risk assessed in key safety areas using nationally validated tools. We noted that when risks were identified it was documented but relevant care plans which included control measures were not always generated. We checked a sample of six patient records on three wards and found no evidence to support that relevant care plans had been formulated. For example with falls, we found very few examples where care plans had been generated as a result of the risk assessment and the "SLIP" care bundle

had not been fully implemented. We found incidents where pressure ulcers were not graded, reviewed or the effectiveness of any treatment recorded. For example on Cambridge J ward we reviewed a patient admitted from CDU with a grade 4 pressure ulcer with no evidence of grading, no Waterlow score and no evidence to support that a Datix had been raised. Although the patient had been seen by the tissue viability nurse there were no records to support what daily care had been applied or what dressings where in use and their effectiveness.

- We saw that when risk assessments were reviewed and repeated they were not always within recommended timescales.
- On some wards risks were communicated to staff using symbols displayed on a whiteboard above each patient's bed. This method of communicating patient needs was not consistent across the medical wards.

Nursing staffing

- Nursing staffing was acknowledged as a major risk area. Common with many trusts, EKHUFT experienced difficulties in recruiting appropriately qualified and experienced nurses. The trust had been proactive in meeting this challenge and had recruited from overseas and employed large numbers of overseas trained staff.
- Nursing establishments had been reviewed in 2014 using the nationally recognised "Safer Nursing Care Tool" which had led to investment in additional nursing posts. During our visit the ward areas were in the data collecting phase of a further review using this tool and were collecting information on acuity and staff numbers for future analysis. The divisional management team assured us that they would act on the data to ensure that nursing numbers could meet demand.
- The numbers of staff planned and actually on duty were not consistently displayed at ward entrances in line with guidance contained in the Department of Health Document 'Hard Choices'. We were told by a ward sister that they did have a form to use but this was no longer used as no one looked at it. The form that was displayed on Cambridge M2 was incomplete and out of date.
- Staff reported that, following an appropriate risk assessment, additional staff were deployed on a shift by shift basis if individual patients required specialist one to one care, or if patient acuity had significantly increased. The ward manager referred to a patient with these needs and we saw risk assessment documentation which was awaiting approval for the additional staffing in order to meet the patient's complex needs.
- Some wards reported that staffing levels had improved dramatically. For example, Cambridge M2 had only one Band 5 nurse awaiting a start date to bring them to establishment levels. Supervisory time was still an issue with some ward managers, who told us they were allocated 40% of their time in a supervisory capacity. They told us that this was not enough to effectively fulfil their management role or support the number of new nursing staff.
- During a meeting with matrons we heard that the recruitment and retention of staff was consistently one of the biggest challenges. Recruitment drives have been undertaken in Europe, with another planned in Romania later in the year and the human resources department had been pro-actively addressing retention of these staff.
- The trust provided data regarding the levels of agency nursing staff used by speciality and ward. We were able to see from this that agency usage varied across the service from 10% to 27.9%. Areas such as the discharge lounge and the respiratory ward placed a heavy reliance on agency nursing. For the period January 2015 to April 2015, the average monthly usage was 27.9%. This meant that over a quarter of staff employed on the ward were agency staff.
- When agency staff were used we found there were no robust arrangements for ward based staff to be assured of the competency of staff working for agencies. The trust had quality standards as part of its contracting framework with NHS Professionals which would ensure competency but there were no systems for this to be checked at the commencement of an assignment. Ward staff were thus reliant on the agency staff themselves being clear about their levels of competency and skill, including medicines administration. Staff expressed concerns over the variability in skills and competencies of agency nurses.
- Staffing turnover for nursing staff appears to have increased year on year especially on the elderly care ward with current rates recorded at 18.6% and for general medical nursing at 17.5%. This was considerably higher than other areas of the trust.
- The shortage of chemotherapy trained nurses has resulted in the chemotherapy facility closure. Staffing

issues were reported to the Cancer Board in June and in order to protect the safety of patients the trust closed the chemotherapy unit but continue to provide chemotherapy services on mobile units which visit Ashford twice per week.

- According to the Clinical Quality and Patient Safety Report submitted to the board in June 2015 there were 17 incidents recorded in May-15 (31 in April 2015 and 49 in May 2014). Following review of these incidents, the trust identified that staffing issues were a contributory factor.
- On Cambridge L ward we saw that there were a high number of patients of high acuity and complexity of needs. We saw in one bay four out of five patients were identified with confusion and dementia. There were a high level of junior nurses on the team who needed a lot of support. Of the staff on duty we identified three Band 5 nurses new in post, one Band 5 who needed a lot of support, one Band 4 and 4 HCA's. We saw that one patient required a fluid balance chart, outstanding from the previous day but this had not been done, nursing notes were incomplete, patients requiring re-positioning had not been moved, no evidence of dementia care and delays in recognition and recording of a pressure ulcer. We saw one patient with a dressing that was falling off as they needed repositioning and a number of patients with food who required support with feeding left unattended. This indicated that the skill mix of staff in some areas was not appropriate for the acuity and complexity of patients.
- Many patients told us that nursing staffing levels appeared stretched and a sample of comments were, "Nurses sometimes come when I use the call bell telling me they will come back but they don't. Another patient told us, "Staff are so busy they just don't have any time to talk to each other let alone you."
- Adequate arrangements for nursing staff handover were in place and staff told us that all staff had the opportunity to ask questions and clarify plans and that relevant information regarding the care and management of patients on the ward was clearly communicated.
- Senior staff described their frustration that the new suite of endoscopy rooms were currently operating with only two rooms commissioned due in part to the lack of available nursing staffing. We saw that recently two nurses had been recruited but delays in the recruitment process following the job offer had resulted in the applicants eventually rejecting the offer. We were told that currently there were 80 nursing hours per week vacant. Optimal staffing levels were 12 but when we reviewed staffing rotas we saw that the unit was consistently working with between nine and 11 staff each day.

Medical staffing

- Consultants represented 32% medical workforce against an England average of 33%. Middle career doctors represented 6% in line with an England average of 6%; Registrars 43% which is more than the England average of 39% and Junior doctors 19% against an England average of 22%. This means there were fewer consultants and junior grade doctors than the England average whilst the proportion of middle career doctors and registrars exceeds that of England.
- Medical staff WTE establishment figures for medical staff as at April 2015 demonstrated that there was a shortfall of approximately 8.5% doctors in post. This equated to 21 at consultant or equivalent level and 56 at other medical grades.
- Turnover rates for medical staff for the period April 2014 – April 2015 were higher than other areas of the trust with speciality medicine at 10.4% and Health Care of Older People (HCOOP) 7.3%.
- Consultants reported that nine new consultant physicians had been appointed since the last inspection but that there was still a shortfall on the junior medical rota for this year. Junior doctors told us that they received good clinical support from their consultants and had access via mobile and texting. We heard examples of when consultants had provided cover for night shifts when no registrars were available. This demonstrated that there was a team ethos for delivering care.
- We found there was a high dependency on locum medical staff within the division. In particular we found that within stroke services for the period December 2014 – April 2015 the average locum usage was 18.9% with a range of 0 – 43.8%. In Health Care of Older People (HCOOP) the rate was 6.94% with a range of 0 – 18.5%.
- Weekend medical cover was provided by a "Hot" and "Cold" team. The "Hot" team provided cover for new admissions and sick patients with the "Cold" system attending to ward patients and discharges. Medical staff told us that there were was poor communication

regarding who was in the relevant team, constant gaps on the rota and high levels of sickness and absence due to pressure of work. They considered this often resulted in unsafe medical care over weekends.

- The Gastroenterology ward was supported by four consultants, providing cover for the ward, endoscopy and out patients. Supporting these consultants should be a SHO and two registrars but we were told that only one locum was the normal cover. The effect of this was the locum was forced to prioritise between relatively poorly patients who had arrived on the ward and required a management plan in place and the constant pressure to discharge patients in order to clear beds quickly. This resulted in delays in patient reviews and staff told us that locums were consistently tired, late to finish shift and patients became frustrated as they were often left waiting all day to be reviewed. At weekends, due to the shortage of staff, doctors only visited the ward to see sick patients but were not able to complete discharge letters. On the occasions when discharge letters were completed they would only be written in late afternoon and as the pharmacy closed at midday, this meant that discharge medications were impossible to obtain.
- During our focus meetings we were told that two junior doctors joining the gastroenterology medical team for their first jobs in the UK felt very unsupported by the organisation. They had received very poor induction, were unable to apply for any annual leave and after two months with the organisation were still awaiting contracts. They described how vulnerable they felt when faced with 15 – 25 patients, no trainees on the team, no registrar cover and their requests for locum cover were refused. Although the consultants were extremely supportive they found the lack of staff and increasingly busy wards resulted in no opportunity for them to participate in any teaching. It also limited their ability to undertake or participate in any audit and afforded no time to ask questions or generally "settle in".
- Medical staffing shortages were still reported to be having an impact on patients waiting to be seen by medical staff following admission in CDU. Staff described how within the last two weeks there had been an occasion when six people were waiting to be clerked first thing in the morning. One patient had been in the hospital bed from 2.00 a.m. and not seen by medical staff until after 9.00 a.m. the following day.
- During focus groups that we held prior to the inspection, we were told by junior doctors that there were concerns around the protocols for who took patients onto their teams from CDU and the handover process surrounding this. This meant that some patients were getting missed and we saw examples of patients moved to wards with no handover. One example of a team not accepting responsibility for a patient resulted in the patient not being seen by medical staff for over 24 hours.
- We saw that there was no dedicated medical team responsible for Oxford ward which was used as an isolation facility and Kennington ward which consistently accommodated outliers. This was confirmed by doctors that we spoke with at our focus meetings.
- We heard at the doctors' forum that there were concerns about medical staffing at night with one Registrar and 2 SHOs covering all of medicine.

Major incident awareness and training

- The trust had recently reviewed and revised the Major Incident and Business Continuity Plan. The policy and associated plan was available on the intranet and in hard copy throughout the hospital. We saw signs displayed in prominent positions in wards and specialist medical areas directing staff to the location of this plan in their area of work. Some staff knew what actions were expected of them, while others felt that they could refer all issues to a senior person. We heard how staff had been introduced to this plan at ward meetings with a supporting video presentation.
- Live exercises to test the plan were scheduled later in the year to coincide with when the majority of staff training has been completed.

Are medical care services effective?

Requires improvement

We rated the effectiveness of medical care services as requiring improvement.

Staff were well supported with good access to training, supervision and development. Junior doctors told us they felt well supported by the senior medical staff and had access to regular training, although pressures of work and lack of staffing often meant they were unable to attend or participate.

Medical care (including older people's care)

Evidence based guidance was used across a range of conditions. There was a programme of national and local audits regarding clinical practice in place. The William Harvey Hospital was performing in line with other trusts in achieving good outcomes for patients with strokes.

We found the majority of policy documents were evidence based and readily accessible on the intranet and in hard copy. However, not all policies were in date and there was no control to provide assurance that those in use were current and this presented the risk that staff may have used out of date policies to guide them in the care and treatment of patients.

The pain management policy was in a draft and was being developed in conjunction with the trust's medication policy. Patients did not consistently receive timely pain relief and we saw records that showed patients had not had their pain assessed. There were no specialist tools in place for assessing pain in patients living with dementia or with a learning disability.

We saw that patients' nutritional needs were assessed with scores recorded and risks identified. However, the use of plans to manage these risks were not always evident in patient records. This meant that patients were at risk that their nutritional needs may not be met.

There was access to designated mental health nurses but this was often problematic especially out of hours. This meant that patients with a mental health problem experienced long delays to be seen by the mental health team under the care of staff with none or limited mental health experience.

Weekend medical cover was provided by a "Hot" and "Cold" team. The "Hot" team provided cover for new admissions and sick patients with the "Cold" system attending to ward patients and discharges.

Patients were asked for verbal consent to be treated and we heard doctors and nurses explaining the care and treatment they were receiving. We spoke with staff about the Mental Capacity Act 2005 and deprivation of liberty Standards (DoLS). Staff understood the basic principles of the Act and could explain how the principles worked in practice. However, there was no evidence to support that staff had received training in the Mental Capacity Act 2005 or DoLS.

Currently there is was no access to therapy staff, dieticians or speech and language therapists (SALT) at weekends. Together with limited access to pharmacy services during the weekend, this greatly impeded patient discharge.

Evidence-based care and treatment

- The medical division used a combination of National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines to guide the treatment they provided. The division had a system for evaluating new guidance from NICE and learned societies and for disseminating this to clinicians.
- There was a divisional audit programme for 2015/2016 which we have seen. 11 audits carried over from the 14/15 programme and a total of 62 audits, 22 of which were national audits. This showed that the trust were engaged in the audit of effectiveness of care.
- We observed effective pathways of care across the medical division in the clinical decisions unit (CDU), the coronary care unit (CCU) and the cardiac catheter laboratory.
- Best practice guidelines were implemented in the stroke unit.
- Staff understood the National Institute for Health and Care Excellence (NICE) guidelines and stated that these were referred to in discussions with staff about patients' care and treatment.
- Clinical policies and guidance was available on the organisation's intranet system. Staff could locate policies when requested. We reviewed policy guidance and policies and judged they were compliant with current guidance and best practice. We noted all local guidance that we reviewed carried a review date that was in the future. However, we found examples of operational clinical policies which had been printed out on wards and were out of date. For example on the endoscopy unit we found that the policy on slips, trips and falls was not the latest edition and dated due for review in 2013. The lone working policy had a review date of 2012. The policies available on the intranet were updated but there was no warning to staff that printed copies might not be the most current or evidence of a watermark stating "Not controlled if printed". This meant that although policy documents were readily available and evidence-based, there was not control to

provide assurance that those in use were current and presented the risk that staff may have used out of date policies to guide them in the care and treatment of patients.

- During the period June 2013 to May 2014, standardised relative risk to re-admission for medical care services at William Harvey hospital was broadly in line with national expectations. However in general medicine where the majority of activity occurred, the relative risk was better than the national expectation at 89.
- We saw that key clinical guidelines, for example the anti-microbial prescribing guidelines, were available to junior doctors. This meant that that current guidance was available for staff to reference.
- The in-patient heart failure service was established two years ago in recognition that the trust was not achieving a good standard of care for heart failure patients according to the audit data from the Enhanced Quality Programme. One heart failure nurse was based on each site, providing outreach services to all wards caring for patients with heart failure. Patients are referred to them via the patient centre or by mobile phone contact. They also visited the CDU and medical wards daily to pick up referrals to ensure that no patients are missed. A programme of information has been developed by this team to ensure that patients understand the importance of self-monitoring, how to identify when the heart failure symptoms are worsening, coping strategies, medication and long term issue they may encounter. This showed how the trust responded positively to audit findings to ensure care matched best practice.
  - As part of the new NICE guidance on acute heart failure the cardiology team have developed an acute heart failure pathway that encompasses the new changes (such as the introduction of B-type natriuretic peptide (BNP) testing) and are working closely with various departments to ensure the safe implementation of the pathway.

Pain relief

- The trust's pain management policy was in a draft and was being developed in conjunction with the trust's medication policy.
- We saw that assessments of patients' pain were included in all routine sets of observations. We noted that as part of "intentional rounding" processes (where staff attend patients at set intervals to check a range of patient-centred issues) staff were required to check that patients were comfortable and record this in patient records. We found there was sporadic use of the intentional rounds assessment and when we reviewed six sets of patient notes we found only one had been completed as directed. Additionally we found that non-pharmacological approaches to pain relief were not routinely explored.
- Staff knew how to access the specialist acute pain team when their advice was indicated. The palliative care team also provided support and advice in the pain control of those who were terminally ill.
- Patients we spoke with told us that their pain was managed well. The 2014 in-patient survey reported that the trust achieved 85% response from patients relating to the effective management of their pain relief.
- We found that there were no formalised specialised tools in place to assess pain in those with a cognitive impairment such as a learning disability or dementia, in use. Staff told us that they used a range of communication methods to assess patient levels of pain but acknowledged that the management of pain in people living with dementia had not been formalised or embedded into practice.

Nutrition and hydration

- We observed that patients were served a choice of foods and that therapeutic diets were managed well. Dietary supplements were given to people when prescribed.
- We saw that meal services times were generally calm and well managed, although not all wards offered patients the chance to wash their hands before eating.
- We observed that generally patients were offered sufficient quantities of fluids and had drinks left within reach and were given assistance to drink. However, we did observe a patient with limited arm mobility being given a drink that was then placed out of their reach. The member of staff did not check if they required assistance with drinking.
- On the stroke unit we saw adaptive utensils and equipment such as plate guards, beakers, and special cutlery were available. This showed there was equipment to support patients' independence with food and drink.
- We saw examples of where some clinical areas had made arrangements for people to eat in a dining-room like environment within the ward environment. The facility was also used for patient activities.

- On the elderly care unit relatives and carers were invited to visit patients at meal times to assist with feeding. Staff told us this initiative had greatly assisted them during a busy time.
- We saw that there were adequate arrangements to ensure food safety. For example we found that food service personnel wore suitable PPE, food fridge temperatures were checked and the temperature of food was checked before service to ensure it had reached safe temperatures.
- On the stroke unit we saw that there were arrangements to ensure that patients who had suffered a stroke were assessed promptly to ensure they had a competent swallow and were not denied food or fluid unnecessarily. We saw that fluid thickeners were used as planned, and patients' received a "mashable" diet when recommended by the dietician. We were advised that nurses would perform swallow assessments and patients would have dietary emergency regimes while awaiting SALT assessment. This showed there were systems to ensure people with compromised swallowing received appropriate food and nutrition.
- We spoke with catering staff on the wards who told us that they were given daily lists of patients' dietary needs and any restrictions. We saw staff using these during food service. This meant that staff responsible for serving patients food were well informed about their needs.
- The trust scored below the England average for Patient Led Assessments of Care in the sections for food.

Patient outcomes

- Overall in medicine for non-elective admissions the average length of stay was 7.3 days which was higher than the England average of 6.9. However, in general and geriatric medicine which represents the majority of the activity the average length of stay was less than the England average. For example in general medicine it was 4 days compared to the national average of 6.4 days.
- During the period January 2015 – May 2015 the trust reported their compliance levels against the 62 day cancer waiting time standards for tumour sites with urgent and long term conditions. Their performance levels ranged between 70.31% - 80.53% against a national target of 85%.
- During 2014/15 38 national clinical audits and three national confidential enquiries covered relevant health services that East Kent Hospitals University NHS Foundation Trust provides. During that period East Kent Hospitals University NHS Foundation Trust participated in 92% national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
- The trust participated in the Sentinel Stroke National Audit Programme which is an ongoing national audit that investigates and analyses the quality of care in stroke services. Hospitals are awarded a score A to E where A is the best. At William Harvey Hospital the stroke services achieved an A rating in September – December 2014 but a decreased rating for Jan – April, 2015 of C. Staff attributed the drop to the loss of a dedicated auditor. A business case has been submitted and approved to have an auditor available on each of the three trust sites. However with 70% of trusts achieving a D rating this indicated that the hospital was achieving good outcomes for patients with strokes in line with the national average.
- The hospital participated in the 2012/2013 National Heart Failure Audit and achieved markedly below the England average in clinical care but slightly better in the clinical discharge category. Scores were better than the England average for three out of the seven standards audited. The trust had developed an action plan to address the issues.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. In data we reviewed for 2013/2014 The hospital achieved worse than the national average for nSTEMI patients seen by a cardiologist or a member of the team and referred for angiography but above the national average for admission to a specialist cardiac unit.
- The Joint Advisory Group on GI Endoscopy (JAG) ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced. Using The Endoscopy Global Ratings Scale (GRS) The William Harvey Hospital participates in the quality improvement system for endoscopy services to achieve and maintain accreditation. Bi- annual self-assessments and governance reports are submitted which provides the organisation with assurance that the endoscopy service

is doing the right things and doing them well; thereby significantly reducing the risk of error in the delivery of services. The William Harvey Endoscopy Unit's accreditation is currently under assessment.

Competent staff

- We were told that all new staff attended a corporate induction programme, supplemented by a local induction. We saw some excellent examples of local induction packs, particular one developed for overseas nurses. Staff we spoke with confirmed they had received adequate induction.
- Staff had skills and training, and this was monitored through the appropriate clinical process.
- Throughout our inspection we observed that staff were professional and competent in their interactions with colleagues, patients and their relatives/carers.
- Staff told us they participated in the appraisals process and we found documentation in ward areas and medical speciality units, together with overarching reports on the central records system to identify current appraisal rates. For example on Cambridge M2 ward we found the appraisal rate was 95%, on CDU 92% and in the Endoscopy Unit 100%. The trust reported that 82% of nursing staff within the medical directorate had received an appraisal.
- Staff attended a wide range of training which was recorded on the central electronic training record.
- We found there was a system for supporting new staff, especially those that were newly qualified when they commenced work. There was a comprehensive competency based programme which they worked through with the support of a preceptor and we saw examples of these and spoke with staff who were undertaking the programme. We noted that there were a wide range of clinical and organisational skills included in this programme requiring formal sign off. This indicated that staff, their managers and patients could be confident staff had the skills to carry out their jobs.
- Staff told us that there were opportunities to undertake additional study, and that the organisation supported them in this. For example we heard how the Superintendent Physiotherapist was supported by the trust to undertake his Healthcare Post Graduate Certificate. We also saw from the specialist heart failure nurses how they have all attended development courses as part of their educational pathway.
- We saw there was a wide range of specialist nurses, for example the dementia care team, palliative care team, safeguarding leads, diabetic care team and discharge co-ordinators who supported staff in ensuring they were delivering competent care. We noted their presence on the wards and staff told us they valued the input of these teams who were proactive at team meetings and on the wards. Staff had attended dementia training but the care of patients living with dementia was not embedded in clinical practice.
- Junior doctors we spoke with reported that although the trust was an excellent place for training, they were often unable to attend teaching due to low staffing levels. We heard how new doctors were still waiting months after appointment for confirmation of their clinical supervisor and spent consistent amounts of time trying to establish their study entitlements.
- There was a robust system to ensure that nursing staff maintained current registration with the Nursing and Midwifery Council.
- Consultants we spoke with confirmed that they participated with appraisals and there were systems in operation regarding revalidation of GMC registration.

Multidisciplinary working

- Within medical care services we identified that there was a strong commitment to multi-disciplinary working. Each ward area had a multi-disciplinary team meeting on at least a weekly basis to plan the needs of patients with complex needs. We saw documentary evidence of a multi-disciplinary approach to discharge planning.
- Ward and specialist medical teams had access to the full range of allied health professionals such as speech and language therapists, dieticians, tissue viability, falls co-ordinators, dementia and diabetic consultant nurses and described good, collaborative working practices.
- Medical and nursing staff of all grades that we spoke with all described excellent working relationships between healthcare professionals. We observed that the healthcare team worked well together to provide care to patients.
- We saw that on the stroke unit all patients' notes were integrated with doctors, nurses and therapists using a single document. This meant that that all members of the team were aware of the input of others, and that care was well co-ordinated for patients and their relatives.

Medical care (including older people's care)

- Consultants we spoke with told us they found the input of other clinical teams and specialist nurses to be very good.
- Staff on the CDU told us that they could access the advice of mental health professionals and their response to referral was prompt during normal working hours but there were consistently pressures on the department to manage patients overnight without any mental health support. The ward manager explained that mental health services were provided on a Kent wide basis by Kent and Medway NHS and Social Care Partnership under a service level agreement. Designated mental health nurses were providing 24 hour cover but this ceased three months ago and staff based in the hospital until 10.00 p.m. consistently are unavailable after 5.00 p.m. We were given an example of one patient under the care of the CAMHS who remained in CDU for seven days whilst awaiting placement. Eventually following an abscondsion and incident involving police the patient remained in the care of CDU in a bay accommodating other patients, with three mental health nurses in attendance. This incident that had been reported resulted in a distressing effect on the other patients on the ward and for the staff.
- We observed a medical handover meeting on the CDU from consultant to consultant. There was one medical registrar in attendance but no other junior doctors were involved.
- We discussed with ward nurses how the continuing care checklist was used to notify the continuing care nurses. Unfortunately a wait of six days was not unusual for an appointment to be arranged for the nurses to visit and assess patients to expedite discharge.
- We spent time with the therapy team on the stroke ward and both medical and nursing teams were very complimentary about the initiative they had introduced and their high levels of multi-disciplinary engagement.

Seven-day services

- The management team described their approach to seven day services as "A constant work in progress."
- New medical admissions were seen every day on one of the twice daily post take ward rounds.
- Consultants from acute and general medicine, cardiology, respiratory medicine and gastroenterology performed a daily ward round including weekends and bank holidays.
- Staff reported that there was seven day availability of all diagnostic services including imaging, (excluding ultrasound) and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours.
- Weekend medical cover was provided by a "Hot" and "Cold" team. The "Hot" team provided cover for new admissions and sick patients with the "Cold" system attending to ward patients and discharges. Medical staff told us that there were was poor communication regarding who was in the relevant team, constant gaps on the rota and high levels of sickness and absence due to pressure of work. They considered this often resulted in unsafe medical care over weekends.
- Currently there is was no access to therapy staff, dieticians or speech and language therapists (SALT) at weekends on the stroke ward which we were advised resulted in delayed discharges. Some nurses picked up some therapy interventions e.g. mobilisation but this was not optimal.
- Endoscopy services provided elective procedures on two Saturdays per month and one weekend in every four weeks.
- With pharmacy services only available until midday at weekends, timely discharge was impeded for patients who were unable to obtain their discharge medication.

Access to information

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for patients. We were told that patients' old notes were retrieved from the hospital archives when required without delay.
- We saw there were systems to ensure the transfer of information when a patient moved between wards and these were supplemented by a verbal handover.
- We saw that the patient flow team and site matrons routinely collected information throughout the day to inform the management of the hospital and the flow of patients. For example we saw that information about patients in the wrong specialty beds (outliers) was collected early each morning and was widely disseminated; we saw copies displayed in ward areas.
- Consultants and junior doctors we spoke with told us they felt there was excellent communication between medical and nursing staff.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In the endoscopy department we spoke with patients awaiting procedures and they told us that doctors and nurses were extremely careful in explaining the procedures before they signed the consent to treatment forms. We saw there were arrangements for nurse-led consent which ensured that patients gave informed consent prior to their procedure. We saw from patient satisfaction surveys that for the period February – May 2015, an average of 93% of patients reported they had been given adequate time to read consent forms prior to signing them.
- Patients told us that staff gained their consent before care or treatments were given. We observed health care assistants gaining patients' agreement before carrying out care.
- There was no evidence to support that any staff had received training in the Mental Capacity Act and Deprivation of Liberty. Staff we spoke with were aware of the requirements of their responsibilities as sent out in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), although some more junior staff said they would seek assistance from managers.
- We saw examples of where staff had appropriately identified that a person's liberty was being curtailed using the High Court definition of 2014. We saw that urgent DoLS authorisations were sought and approved by an appropriate member of trust staff and that standard authorisation were sought from the relevant supervising authority. We saw that consideration was given to using the least restrictive option.
- The Adult Safeguarding team had been renamed the "People at Risk Team" (PART). This team had responsibility for overseeing the implementation of MCA and DoLS within the hospital. Staff we spoke with knew how to contact the team and told us they valued their support and advice.
- We saw that there was a standard checklist in place with information regarding best interest meetings and supporting documentation for staff to use when concerns about any patient whose liberty needed addressing.

Are medical care services caring?

Good

We judged that the caring aspects of medical care services were good.

This was because patients and their relatives were positive about their experience of care and the kindness afforded them. We observed care that was compassionate from all grades of support and clinical staff. We also saw, and patients told us, that privacy and dignity was maintained at all times.

Patients were involved in their care and treatment and were given the right amount of information to support their decision making. We found there were arrangements to ensure patients could get the emotional support they needed.

Compassionate care

- The trust use the Friends and Family test (FFT) to get patients views on whether they would recommend the service to family and friends. FFT figures are used to calculate the net promoter score which enables trusts to be compared. We looked at the latest FFT scores that were available to us and during the period December 2013 to December 2014 the response rate for individual wards ranged from 18 - 69%. We used eight medical wards for the period June – November 2014. The score for this period averaged at 87 out of 100 for med care services at The William Harvey Hospital. The results can produce scores between -100 and +100 a score over 50 is considered to be excellent.
- Data taken from the cancer patient experience survey results for inpatient stay for the period 2013/2014 showed a score in the bottom 20% of trusts for being given enough privacy when examined or treated,
- In many areas we saw that confidential patient information was displayed in the public area on large whiteboard information boards. We asked ward managers if this raised concerns regarding patient confidentiality and were informed that it was necessary for the running of the ward and was essential as they did not have the benefit of an electronic board, capable of displaying initials.
- The patients who contacted us prior to the inspection, and through our various listening events, told us that

the care was usually very good and the staff were excellent. We heard some patient's stories where care was less than ideal, but when reported, the issues were always dealt with promptly and appropriately.

- During our inspection patients told us that staff worked extremely hard to ensure their comfort but that there were not always enough nurses on duty, particularly at night. A sample of comments were, "Nurses sometimes come when I use the call bell telling me they will come back but they don't" and "Staff are so busy they just don't have any time to talk to each other let alone you".
- We observed that interactions between nursing staff and patients were professional, kind and friendly. An example of this was observed in the discharge lounge with a HCA ensuring that a patient was comfortable, had a hot drink and then taking time to read and explain the contents of their discharge letter. The patient told us "The staff are angels and so patient with me".
- Patients told us that the nursing staff were respectful to them and every effort was taken to ensure their privacy was protected when personal care was being given.
- We spoke to 27 patients and five relatives who all told us that the care at the hospital was "very good". Comments included, "the staff are so kind and caring you cannot fault the nursing care", and "I am always happy to come back to WHH, I'm so pleased that it is my local hospital."

Understanding and involvement of patients and those close to them

- Patients we spoke with confirmed that they understood their treatment and care plans. They described conversations with the doctors and consultants and had been told how their illness or injury might improve or progress. Where alternative treatment options had been available, people told us that they had been given all the details of the various options and how these might affect their condition and overall health and had been able to decide which treatment to undertake.
- Data taken from the cancer patient experience survey results for inpatient stay for the period 2013/2014 showed that the trust was in the top 20% of trusts with regard to patients being given clear written information post discharge, patients given enough care from health or social services, patients being given correct information and patients told who to contact post discharge. However they score in the bottom 20% for: staff gave explanation of what would be done, patients not feeling that they were treated as a set of symptoms and staff did everything to control side effects of chemotherapy. However, the audit was trust-wide, and did not indicate separate results for each of the hospitals.
- The stroke unit had introduced initiatives to improve the engagements of patients and their families in planning their care and discharge by introducing a family meeting within two weeks of admission. A further meeting is then held two weeks prior to discharge. We reviewed six sets of patient notes and were able to see how this involvement had been recorded and used to support the needs of the patient.
- In-reach and out-reach services have been developed by the stroke therapists in conjunction with community colleagues to promote a seamless transfer of care.
- We found that when patients were supported by their carers during their stay in the hospital there were no clear lines of responsibility agreed or in place to ensure that the patient received the appropriate care at the right time. For example on the stroke ward we spoke with a patient who was supported by their carer who had not been toileted between 8.00 a.m. and 11.30 a.m. The carer told us they were upset that when they approached a member of staff for assistance they were treated abruptly and told that it was the carer's responsibility. The carer also remarked that cleaning staff assumed that it was the carer's responsibility to empty bins. This meant that the patient might not receive the appropriate care in a timely way.
- Patients told us that generally they were kept informed of their care plans, and were involved in developing these. Where appropriate, they told us they were given choices about the care and treatment options available.
- We found patients were given information to help them understand their disease and its treatment. For example we observed a physiotherapist describing the benefits of the programme developed for them. We noted that plain English was used and that the communication style was appropriate to the patients' needs.

Emotional support

- Patients, their relatives and supporters told us that generally the clinical staff were approachable and that they could talk to staff about their fears and anxieties.

Medical care (including older people's care)

- We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care and that these staff offered appropriate support to patients, their families and carers in relation to their psychological needs.
- In the endoscopy unit there was a discharge room which enabled staff to speak with patients and their families confidentially. However, there were not always dedicated private areas in other medical ward areas where patients and their families could go to discuss issues with medical staff or amongst themselves issues relating to care and emotional support. For example on CDU we were told by staff that very often they were required to deliver personal and difficult news in corridors.
- There was a hospital chaplaincy service supported with an information booklet which was seen displayed throughout medical services. A chapel and prayer room facility was available together with rooms set aside for use by those belonging to other religions than Christian. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families.

Are medical care services responsive?

Requires improvement

We judged that the responsiveness of medical care services required improvement. This was because there was insufficient bed capacity to meet the needs of patients. This resulted in almost half patients being moved at least once during their hospital stay. There were large numbers of patients in non-speciality beds and this had negative implications for their safe care and treatment. We also found that support for people with mental health needs was variable and the discharge of patients was not managed in a timely manner especially at weekends.

We found that there were arrangements to meet the individual needs of patients and that considerable developments were in progress to improve the care of people living with diabetes and dementia although the benefits of these were not yet fully embedded into practice. Endoscopy services were not meeting national targets and this meant that patients were not able to access services for diagnosis and treatment when they needed to. With the closure of the chemotherapy service we found that the organisation was not meeting the needs of the local population by providing care close to home. We saw that there were systems to promote planned discharge from hospital that was planned and met the on-going health and care needs of patients, but the lack of pharmacy staff impeded this and resulted in unnecessary delays.

Service planning and delivery to meet the needs of local people

- Patients were admitted to medical wards via the accident and emergency department or their GP. GP requests were assessed in the CDU. This incorporated the ambulatory care unit where patients could be assessed in chair spaces rather than beds.
- This ambulatory care was provided so as to provide care closer to home and avoid unnecessary admissions. However, a doctor expressed concern that this area was not ring-fenced and had been used as extra capacity for medical inpatients when seasonal pressures necessitated this. This meant there was variability on the provision of a service designed to meet the needs of local people.
- Demand for medical beds frequently outstripped supply especially in the winter period. In these circumstances patients could be placed in additional beds outside of the speciality. There were arrangements to ensure that outlying patients were reviewed by speciality teams and nursing staff reported they worked well.
- We saw that the patient transport department was located within the discharge lounge to assist with transport arrangements as quickly and efficiently as possible.
- We saw examples of usual visiting hours being varied to accommodate the needs patients and visitors with extra-ordinary circumstances or who were very sick. We saw examples of relatives being supported to stay with a very sick patient during our visit. Visitors had been encouraged to visit elderly and frail patients during meal times to assist with feeding.

Patient flow

- The Urgent Care and Long Term Conditions Division have re-launched the new acute medical model on the William Harvey Hospital site with the aim of reducing hospital admissions, facilitating early discharge and improving patient flow through the emergency

department, CDU and the medical wards. This means that dedicated acute consultant physicians and the acute nurse consultant lead acute medical care on CDU and the ambulatory care unit. The acute physicians rather than specialist consultants assume responsibility for all patients between 8 am and 2pm. Staff on CDU told us this was working well and we attended a handover during our visit.

- The hospital held bed management meetings twice per day to look at the flow of patients across the hospital. We observed one bed meeting in the afternoon on the day we inspected. Nursing staff reported on the number of empty beds on their wards, patients who were due to be discharged and the number of patients that could potentially be discharged. We found that here was no discussion about what needed to be in place to discharge the patients that could be potentially discharged. Staff told us that the hospital had been running at full capacity and that it was only recently that they had seen a reduction in the number of patients in the hospital. The trust held twice daily video operational meetings across each of the sites, mid-morning and late afternoon where the bed capacity of each site was discussed
- From the data we reviewed for the period June 2013 – June 2014 the average length of stay for patients in medical services at the hospital was below the England average showing cardiology 4.7 days (England average 5.5) general medicine 4 (England Average 6.4) and geriatric medicine 6.9 days (England average 9.8).
- The trust was meeting the referral to treatment time targets for all medical specialities. With a range of 90.9% to 100% compliance with the 18 week target set nationally. We reviewed showed data that demonstrated there was currently a 30 day waiting time for patients on the cancer pathway. We were told by senior staff that following a national awareness campaign there had been a significant increase in referrals and with inappropriate referrals and the availability of consultants this had contributed to the delays. Consultants had established a triage to streamline referrals and an additional locum consultant had been engaged but the situation was slow to improve. Current routine referrals to the unit waited on average six weeks. We saw that this information was monitored at board level.
- We found that during busy periods the discharge lounge had been used to accommodate patients overnight prior to undergoing endoscopy procedures. This had last occurred on May 19th, June 4th and June 18th. We saw emails to support requests had been made by the bed management team to reserve beds on two or three occasions a week. The clerking process and diagnostic observations were undertaken whilst the patient was in the discharge ward and they could be accommodated from 6.30 p.m. until 7.00 a.m. the following day if a suitable bed did not become available. Staff reported that this had recently ceased and they were relieved as they frequently had to manage patients who were angry and disappointed at these arrangements. When we discussed this with the Divisional Head of Nursing we were told they were unaware of this but would investigate.
- We found that due to issues with patient flow, medical patients were transferred or admitted to beds designated for other specialities. During the period May to July 2015 statistical information provided by the trust showed these to be between 248 and 325 per month. This showed that medical care services were unable to care for patients within their allocated bed base.
- During the period April 2014 to April 2015, 29% of patients experienced one ward move, 16% were moved twice, 6% three times and 3% were moved four or more times. This showed that nearly half of patients were not treated in the correct speciality bed for the entirety of their stay.
- We spoke with nursing staff and therapist who told us they felt that whilst there were arrangements to ensure that outlying patients were reviewed by speciality teams, there were occasions when doctors were difficult to contact and that consultant reviews were less likely to occur daily.
- Mixed sex accommodation breaches are reported in the monthly Clinical Quality & Patient Safety Report, including those that occurred as being within the agreed scenarios. Medical care services reported there had been no breaches of guidance on mixed-sex accommodation since April 2014.

Meeting people's individual needs

- We saw that patients had their needs assessed but there was not always a supporting plan of care devised to meet their identified needs and thereby minimise any risks to which they were subject. We found that nursing assessments were rarely fully completed. On Cambridge L ward we reviewed six sets of patient records and found

that in all cases the nursing assessment had not been completed. There appeared to be no consistency in the organisation of medical and nursing documentation which sometimes made navigation of the records difficult.

- We saw that a system of "intentional rounding" had been implemented to ensure that patients' fundamental needs were met. We saw that records were kept of these care rounds and noted that generally they were carried out at the specified frequencies. However, we did note that sometimes during early morning and evening records showed that these rounds were carried out late or not at all.
- The trust employed a team of specialist dementia nurses and learning difficulty link nurses. We were told that these members of staff were an invaluable resource, providing support, training and developing resource files for staff to reference.
- We did not see any pictorial aides for use with people with learning difficulties, nor did we see the use of a standardised communication tools (for example traffic light documents, or patient passports) that enabled community staff or family members to highlight any special needs the person with learning difficulties may have.
- We noted that patient assessments identified when patients had sensory deficits and this was factored into care planning. We observed specialist equipment in use to aid communication with a deaf patient.
- We saw that there were adequate supplies of mobility aids and lifting equipment such as hoist to enable staff to care for patients.
- Hospital mattresses were it for purpose and provided protection from infection and pressure damage. Where the risk of pressure damage was particularly high, staff could access specialist dynamic mattresses to ensure patients' needs were met and they were protected.
- We saw that clinical ward areas displayed printed health-education literature produced by national bodies. Some of this information was general in nature whilst some was specific to the speciality of the ward. For example, literature about living a full life following a stroke and diabetes care with information about associated charities and support groups was displayed. We noted that all publications were in English with no information on how to obtain copies in other languages. The exception to this was the guide on chaplaincy services.
- Staff were able to access interpreting services for people for whom English was not their first language. Polish and British Sign Language were the languages most often requested. We spoke to a patient on the stroke ward whose first language was Nepalese. The patient's relative was able to provide general support with the availability of a translation service for specific meetings and for doctors' visits.
- The hospital scored significantly below the England average for Patient Led Assessments of Care in the sections of dementia with a range of 25% - 86.21%.
- We found that some initiatives had been introduced in wards accommodating patients living with dementia, such as coloured toilet seats, but this was inconsistent. We noted that the environment of the ward designated as a ward specialising in the care of people living with dementia was not dementia friendly. Reminiscence displays had been introduced on some wards and dementia cafes set up in the discharge lounge to assist in the care of people living with dementia.
- We saw that the "This is Me" assessment document produced by the Alzheimer's Society was in use on some wards but did not find it widely used to notify staff about the social history of people living with dementia or as a method to alert staff to care preferences or any special considerations relevant to their care. We found the document included in many patient care notes on the elderly care ward but not completed, which means that it was a lost opportunity to engage patients' families in completing these documents in order to communicate their personal knowledge of the patient. Staff we spoke with were aware that these documents were available and often in use and told us they found them helpful when utilised.
- We found that there were arrangements to ensure the requirement that all patients aged over 75 years were screened for dementia within 72 hours of admission for dementia. We saw that the trust was consistently meeting their target with an average of 90% screening rates.
- Staff explained that they could access bariatric equipment when it was required, and gave examples of how they had ensured it was ready and in place before a patient was transferred to their care.
- We observed that one patient was allocated a member of the patient security team whose role was to provide

one to one observation. Staff told us this was of great assistance to them on the wards and often requested for patients who lacked mental capacity and presented with challenging violent behaviour.

- We discussed with staff the current cancer pathway waiting time of 30 days for routine referrals which they said was attributable to an increase in referrals due to national awareness campaigns, inappropriate referrals, holidays and the availability of consultants. Plans were in place to streamline referrals by triage as staff were consistently finding it difficult to explain to patients why it was taking longer than 14 days.

- When we spoke to junior doctors at a forum we were told that only one consultant in the trust was able to perform Endoscopic retrograde Cholangio-Pacreatography (ERCP) and when this consultant took annual leave patients were transferred to London hospitals for treatment. This was instrumental in creating a poor patient experience of the service.
- Patients and relatives we spoke with were generally satisfied with the quality, range and choice of food that was offered. Food that met people's special cultural and religious needs was available. There were facilities that enabled families and visitors to purchase food and beverages. However, there was no vending facility in the discharge lounge for patients or relatives to obtain hot drinks.

Learning from complaints and concerns

- We saw that a new trust complaints policy had been introduced. This was available on the intranet for staff to access.
- We noted that information on how to raise a concern or complaint was prominently displayed in clinical areas throughout medical care services.
- We asked two members of staff about the Patient Advice and Liaison Service (PALS) and they were conversant in what support services would offer to patients and how it could be accessed. This demonstrated that patients could access the information and support they needed to progress a concern or complaint.
- During the period January – March 2015 there were 52 complaints received for the medical division. The top three themes for complaints received were for delays, concerns about clinical management and problems with communication.
- Each speciality reviewed complaints in depth on a quarterly basis and we saw from The Clinical Governance Report for Gastroenterology for the quarter to March 2015 that nine complaints had been received in the speciality with four being upheld. Further analysis identified a trend of complaints around doctors' attitudes and communications, OPD arrangements and the timeliness of referrals being booked for diagnostic tests. This demonstrated that complaints were reported and discussed at trust divisional and speciality levels.
- We saw evidence to support that complaints were investigated, learning points identified and feedback given at ward meetings.
- A trust-wide complaints newsletter has been produced for disseminating the learning from complaints to staff in the trust. The first issue was sent out in June 2015 and was also attached to the organisation's internal newsletter to staff. The newsletter contains the complaints and compliments data for the quarter for each division and includes case studies identifying service improvements within the trust as a result of complaints.
- Real life anonymised complaints were used by ward teams to act as discussion and learning aids and were also presented on the trust website for learning.

Are medical care services well-led?

Good

Overall, we judged that medical care services were well led.

Staff acknowledged the steps that had been taken within the organisation to improve structures, processes and systems of accountability. Staff were aware of the trust and local service vision and incorporated this as part of their daily work. Individual wards and units had developed their own strategies which staff understood. We noted that staff showed a positive attitude to their work and spoke well of the organisation and their colleagues. They expressed a slowly growing confidence in their leaders and told us they were now more visible and approachable, and supported them to do their jobs well.

We found there was an appropriate system of clinical governance in medical services that identified risks and

underperformance in key safety areas, and the remedial actions required to monitor performance. The governance system used comprehensive system of metrics presented as dashboards to ensure that quality and risk issues and trends could be readily identified and learning was disseminated to staff. There were examples of collaborative working with the voluntary sector and where patient representatives had been involved in developing and monitoring services.

We observed a caring and positive ethos, and staff acknowledged developments to embed a more cohesive culture of openness between senior managers and staff. Staff reported that although the culture was slowly improving they still did not always feel actively empowered or engaged with improvement being reactive and focussed on short term issues.

We found that staff and patients were engaged with the development of medical care services, and saw examples of innovative practice.

Vision and strategy for this service

- The trust have undergone a level of change which was described by the Interim Chief Executive as "embarking on an improvement journey". Managers and staff demonstrated understanding the trust vision which is to be known as one of the top ten hospital trusts in England and the Kent hospital of choice for patients and those close to them. They described how the organisation's mission to provide safe, patient focussed and sustainable health services with and for the people of Kent was simple but something they felt committed to.
- We saw examples of where wards and medical speciality services had developed their own vision for example on Cambridge M2 we saw displayed the ward vision using the word NURSE. A healthcare assistant told us how this had been a collaborative effort with all staff involved in developing the team vision. Staff in the Stroke unit had developed a set of service principles that staff signed up to.
- All staff we spoke with at The William Harvey Hospital knew who the chief executive was, and most staff were aware of the trust's initiatives to involve staff in the wider organisation, for example, staff presentations for improvements for the hospital and the Chief Executive forums.

Governance, risk management and quality measurement

- We found medical care services had a robust governance structure. Governance activity was co-ordinated by a dedicated post-holder. Each speciality held clinical governance meetings attended by the lead and other consultants, matrons, ward managers and the governance lead.
- We saw evidence in the form of minutes of meetings, which showed that regular team and management meetings took place. We saw how these meetings had been used to share information about complaints and incidents but also to share good practice and positive feedback.
- Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its goals.
- We saw that ward managers were provided with regular reports on incidents that occurred in their areas, complaints, survey results and staffing data. This information was discussed with the matron for the area who monitored for themes and trends.
- Staff reported that although staffing levels and skill mix were constantly reviewed the lack of sufficient numbers of staff in some areas impacted greatly on the quality of the service. We attended a staff handover session where managers described the process of assessing the acuity and needs of patients on the wards and ensuring staff were made aware. Staff confirmed the process and we were shown how bay notice boards were used to display information as a constant reminder to staff of people's needs.
- We spoke with the ward sisters across all medical services who demonstrated a good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, keeping a risk register and undertaking audits. Where necessary the trust had reviewed and increased resources to ensure audits were undertaken.
- The organisation had a robust system for maintaining an accurate and current risk register for the division. Any member of staff could raise an issue for inclusion with the governance lead. After assessment control measures were identified to manage the risk. All managers we spoke with knew risks contained on the divisional and corporate registers and their status demonstrating

understanding of the process. We looked at the registers and noted all the risks we had identified or had been informed of were included. We also saw that targets had been set with regards to actions planned to reduce risk, and that progress against these was recorded demonstrating active management of identified risks.
- The trust had developed a leadership development programme, using external training expertise to support all people managers. We spoke with a matron who was enthusiastic about participating in this and the roll out later in the year to front line managers.
- Staff in the stroke unit were complimentary about the strength of the unit's clinical governance and felt that they had a strong unit that was well led with quality improvements in place.

Leadership of service

- Managers within the service were knowledgeable about the improvements within the trust improvement plan and their area of responsibility to support the organisation in providing care to patients that meets and exceeds the standards expected. We were told that many staff reported that gradually they felt more empowered to be involved in the changes rather than "watch it happen".
- Ward managers told us that matrons and members of the executive nursing team could be seen on the ward regularly and were approachable and helpful. Staff told us that they felt supported by their line-manger to do their jobs well despite challenges, especially of capacity and recruitment. Staff of all grades were aware of the need for improvement; the challenges faced by the service and were aware of, and engaged with actions to mitigate the effects of quality and safety of care.
- Leadership at local service level was good. Staff told us that they were generally supported by their managers and department heads. Senior managers, matrons and heads of departments met regularly. Issues which required escalating were taken forward to the board to be dealt with. Results were communicated back to teams.
- Consultant's described a successful consultants 'forum held in May with another planned for July.
- The Leadership academy was accessible for all staff who have completed the Clinical Leadership Programme, the Aspiring Consultant Programme, the Medical Clinical Leadership Programme or equivalent. This enables skilled clinical and systems leaders to work together as a critical community.
- We saw evidence of nursing numbers and skills mix being reviewed regularly. Wards had strong leadership from matrons and the director of nursing was well-known to staff and seen in clinical areas.
- The trust have increased the format and frequency of the CEO forums for staff which are held monthly on different hospital sites to engage as many staff as possible. Staff we spoke with were knowledgeable about these forums although they said that shortages of staff often made it difficult for middle grade staff to attend.
- Staff told us they understood recruitment was still a problem and the problem is slow to resolve with examples of staff that had left because of stress and the inability to cope with the work pressures.

Culture within the service

- We observed that staff were positive about working for the trust, and took pride in the contribution they made personally to the care and treatment of patients.
- Staff we spoke with told us they felt there had been a shift within the organisation resulting in a culture of openness that had not previously been evident. This was early days and several managers felt strongly that senior managers needed to keep the momentum going in order for this to be embedded into everyday practice. For example, we saw a message from the Chief Executive encouraging staff to engage with our inspection team and to give an honest account of their achievements and challenges.
- Initiatives have been introduced with the establishment of a confidential report line. The introduction of a "Respecting each other" campaign, supported with a video and a culture change programme that has spear headed the organisation's approach to change. They explained how they regularly interacted with the chief nurse's visits to the ward and were positive about the interest they showed in their current projects, particularly supporting the dementia knitting club that had been introduced on the ward. They also said they felt empowered to raise any issues or concerns.
- The workforce was ethnically diverse with numbers of overseas-trained staff, especially nurses in post. The trust had participated in recruitment from abroad at a

time when it was difficult for the NHS to recruit sufficiently qualified people in this country. The location of the hospital presented problems with the retention of staff due to its close proximity to London and the demographic makeup of the area. We saw that staff were enabled to observe their cultural identity. We were not told of any instances of discrimination and noted that staff from non-white British backgrounds had been promoted to senior positions.

- The trust had a number of staff in different areas who were recruited from overseas at a time when it had been difficult for the NHS to recruit sufficient qualified people in this country. We spoke with some of these staff. They told us they were treated well and respected by their fellow workers and managers.
- Patients acknowledged a positive and caring ethos and were generally happy with their experience of care. Where there were concerns patients felt able to raise concerns with staff.
- We spoke with the clinical lead who described the culture of consultants as positive, collaborative and pro-active with increasing involvement in clinical leadership and in quality and governance initiatives.

Public engagement

- Patient satisfaction surveys were conducted by the trust and in addition staff told us that they regularly canvassed patients to ensure they were happy with the treatment and care they received, they explained that this wasn't routinely recorded unless an issue was raised which couldn't be addressed there and then.
- Stroke services had introduced ward based patient groups run in conjunction with charitable organisations such as the Stroke Association and Headway. A comprehensive welcome pack containing a wide range of information to inform and support patients has been produced. This meant that patients and families were given access to resources to help them understand and adjust to stroke and traumatic brain injuries.
- Patients had access to the Patient Liaison and Advice service (PALs), to provide information about NHS services and support to deal with concerns or complaints.
- Information was available to patients with visual signposts displayed to the local Healthwatch organisation, including a link to Healthwatch on the trust website.
- A "hello my name is …" was widely known by staff and during our visit and we heard examples of staff practicing this when engaging with patients on the telephone and at the bedside.

Staff engagement

- Cluster meetings held on Fridays for Ward Manager's facilitated opportunities for staff to exchange ideas and experiences. We saw from notes that other staff including endoscopy staff, dementia care link nurses and assistant ward managers were encouraged to participate in the meetings.
- The trust conducted staff satisfaction surveys in line with national policy. The latest published survey results for show that 2924 staff responded. This is a response rate of 41% which is worse than average for acute trusts in England, and compares with a response rate of 50% in this trust in the 2013 survey.
- All the staff we spoke with assured us they understood the organisations whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.
- We saw evidence during our inspection of information displayed on staff notice boards promoting the monthly staff recognition programme "You made a difference" which aims to recognise staff that have been nominated by their peers for having "gone the extra mile".
- The endoscopy unit had initiated a "Team member of the month" and encouraged all staff to sign into the unit "Code of Behaviour". Staff told us this had boosted morale and encouraged an inclusive and responsible ethos within the department.
- Generally staff described an environment with an evolving transparent, diverse and supportive ethos. We found through our discussions with all grades of staff that staff felt informed and involved with the day to day running of the service, and its strategic direction.

Innovation, improvement and sustainability

- Initially to support staff with the CQC inspection the organisation had introduced an improvement hub. This was in a dedicated room and manned at publicised times to provide an opportunity for staff to obtain

information and contribute with suggestions, comments and experiences. Staff reported that this was a very useful resource and we were told that on occasions up to 200 people had attended an information forum.

- We saw that individual ward and departments held ward meetings, and or issued newsletters to staff to keep them informed.
- Monthly video-link trust-wide meetings held with diabetes teams including consultants and nurses, supported with face to face meetings held every three months has been instrumental in galvanising the "Think Glucose" initiative.
- Therapists in the stroke unit are at the forefront of innovations in stroke rehabilitation with members of the team being keynote speakers at international stroke summits.
- We saw that the division had identified a range of cost improvement plans (CIP's). We saw that appropriate risk assessments had been carried out to understand their potential risks to quality and safety.
- The governance system used comprehensive system of metrics presented as dashboards to ensure that quality issues and trends could be readily identified. We found that through its clinical governance and performance review structures and processes, the divisional management team were well placed to ensure that improvements needed were identified and that performance across a wide range of metrics was sustained.
- The trust received an award in January 2015 for the most improved acute trust with regards to the Enhanced Quality Programme for heart failure, pneumonia and enhanced recovery.
- We received correspondence from a research fellow working within the trust, taking part in a national NIHR – funded project evaluating a tool to improve the care of people with dementia, who commented on the commitment of staff to the project and the support received from the leadership. In particular to the Chief Executive finding time to attend initiatives such as attending the staff "singing for wellbeing" choir. One of the comments was; "Such support and interest means a lot to staff at the sharp end".

Surgery

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

Information about the service

The William Harvey Hospital (WHH) has seven surgical wards, a fracture clinic, a central admission lounge, a day surgery and theatre unit, and a main theatre suite. The hospital currently provides emergency, general, trauma and elective surgery. For the period July 2013 to June 2014 surgical activity at The William Harvey Hospital was predominantly day case work, at 43%. Elective surgery contributing 22% of activity and emergency surgery 35%. Trauma and orthopaedics was the highest area of activity, at 36%, followed by general surgery, at 24%.

During our inspection, we reviewed information from a range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, visited the surgical wards, operating theatre department, pre-assessment and the day surgery unit. We also observed care being delivered by staff. The CQC held a number of focus groups and drop-in sessions where staff could talk to inspectors and share their experiences of working at the hospital. We spoke to 44 staff, 12 patients and three relatives.

Summary of findings

Patients who used the service experienced safe, effective and appropriate care and treatment and support that met their individual needs and protected their rights. The care delivered was planned and delivered in a way that promoted safety and ensured that peoples individual care needs were met. Staff provided care that was compassionate and all patients were treated with respect and dignity. Patients had their individual risks identified, monitored and managed and the quality of service provided was regularly reviewed.

Staff were competent and knowledgeable about their specialties on both the surgical wards and in the theatre units. Mandatory training was not always up to date and there were gaps in the knowledge and understanding with regard to mental capacity.

We found the clinical environments we visited to be very clean, as were equipment items.

Hospital-acquired infections were monitored and rates of infection were in an acceptable range. Outcomes for patients were good and the departments followed national guidelines. Departments undertook frequent audits such as the theatre checklist and hand hygiene. Audits were analysed and the results cascaded to staff.

Complaints were investigated and handled in line with trust policy. Patient complaints and comments were used as an improvement tool to positively impact on patient care delivery.

Surgery

Leadership in all areas had improved. Senior staff were visible, available and supportive to all staff.

Are surgery services safe?

Good

The surgical wards used the safety thermometer to monitor and assess the quality of care being delivered. We saw patients care needs were assessed, planned and delivered in a way that protected their rights and maintained their safety. The hospital used an electronic Early Warning Score (EWS) to identify and monitor deteriorating patients and the care pathways we reviewed provided an audit trail of the actions taken by staff when patients deteriorated.

Incidents were reported, monitored, investigated and learned from and reported as per policy. We found there were enough staff on duty to meet patients' needs.

Staff had not always received appropriate mandatory training to ensure the safe delivery of care.

Incidents.

- There was one reported Never Event for the location between the period of May 2014 and April 2015, which we found had been fully investigated and acted upon. Information form this event had been communicated to staff, so that shared learning was achieved. For example, we were able to view a formal presentation related to wrong site anaesthetic blocks. This detailed the required actions and improvement plan staff were to follow. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.)
- We found that learning from incidents was consistent and led to changes in practice to ensure patient safety. The majority of staff we spoke with were able to describe in full the reporting process for incidents. Staff who were asked to demonstrate the process for completing incident reporting on the hospital database were confident in showing the system to us. Feedback and learning from incidents was cascaded to staff in theatres at staff meetings and during educational days, which were held bi-monthly. An example of shared learning resulting in a change of practice is an incident where a patient received an anaesthetic block in the

wrong site. As a result the department launched a 'Stop before you block initiative, with notices up in all anaesthetic rooms. On the wards feedback from incidents was generally delivered at staff meetings.

- Serious Incidents (SI) are serious matters requiring investigation and were to be reported to the National Reporting and Learning Service (NRLS). There were 15 serious incidents (SI) reported between the period of May 2014 and April 2015, of which six were attributable to general surgery and trauma and orthopaedics respectively.
- The trust submitted documentary evidence that confirmed Mortality and Morbidity (M&M) meetings happened regularly in all surgical disciplines. We viewed data that demonstrated M&M reviews were firmly embedded within the surgical department. We attended one of these meetings, which occurred every two months and saw that consultants, specialist registrars and junior doctors attended. We observed that open discussions took place, which were detailed and provided an opportunity to explore each case and learn from any findings.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred. Senior clinical staff were more confident in describing the process to us. Whilst other staff did not necessarily understand the terminology, the processes they described relating to incidents reflected openness and transparency in communicating to individuals concerned.

Safety thermometer

- The clinical areas we visited were able to demonstrate routine data collection for the national safety thermometer. We saw evidence that safety thermometer data was being used and that this had improved the quality of care.
- The safety thermometer prevalence audits between December 2013 and December 2014 identified 32 new pressure ulcers, 49 cases of urinary tract infections arising in patients with a catheter in situ. There had been 233 patient falls across the surgical wards between July 2014 and June 2015, of which two patients had more than one fall. We noted there were eight cases of harmful falls reported.
- We observed documentary evidence in ward areas that demonstrated good clinical practice in relation to pressure area care delivery. Patients had risk assessments in place and where a risk was identified, action was taken to ensure a patient's position was regularly changed and they had an appropriate pressure relieving equipment in place and specialist nurse input where required.
- We saw day surgery patients had anti-embolism stockings in place where there use was indicated. We also found patients were having their risk of developing a venous thromboembolism (VTE) assessed.

Cleanliness, infection control and hygiene

- We found the surgical wards and theatre department to be adhering to national infection control guidance. We saw a very high standard of cleanliness in all the areas that we visited.
- We found ample supply of alcohol hand sanitising gel for visitors and staff.
- Staff confirmed there were ward based infection prevention and control (IPC) link nurses. We discussed with a link nurse their role, which was to attend IPC meetings and training updates, before cascading this to the ward staff.
- We saw from results displayed on wards that there was IPC auditing taking place with respect to hand hygiene practices. Results of audit outcomes were displayed on ward performance boards. For example, King's A2 there was in excess of 90% compliance with hand hygiene during June 2015 and 96% had been achieved in the first week of July 2015.
- There dedicated staff for cleaning ward areas and the theatre departments. Patient experience feedback for the month of June 2015 indicated cleanliness to be in the amber or green benchmark range of satisfaction. Scores were above 84 and up to 96 across surgical wards.
- Domestic staff were supplied with nationally recognised colour coded cleaning equipment and knew how to use this correctly to minimise risk of cross contamination.
- There was information displayed to guide staff in the required cleaning standards and frequency.

Surgery

- We saw that weekly cleaning audits were carried out and we saw evidence of these. A monthly environmental audit also took place and we saw the results of the audit dated May 2015. Within this main theatres scored 76% and DSU 73%. The issues highlighted from this included some damage to walls, doors and floors. An action plan was in place for a maintenance programme to address these issues.
- A clinical and environmental audit was also conducted on a quarterly basis. The latest audit was May 2015 for which we saw the action plan for. This included issues surrounding the cleaning of new anaesthetic equipment and a new cleaning schedule commenced in July 2015. This demonstrated that learning had taken place as a result of the audit results.
- There were separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for re-processing by the external decontamination service.
- Surgical wards were found to be clean or in the process of being cleaned. One patient told us "that it was all very clean and had no complaints".
- There was guidance to direct staff on the cleaning of equipment used by patients. Commodes and other patient equipment was checked and found to be clean. Labels indicating when the items had been cleaned and by whom were attached to items. A commode cleaning audit for King's A2 indicated 95% compliance up to the time of our visit.
- We saw that staff had good access to personal protective equipment including gloves and different aprons in all areas visited and staff used these during the course of their activities.
- We found that whilst paper copies of a number of IPC policies were out of date, the version on the trust intranet had been reviewed and updated.
- We observed ward staff and allied healthcare professionals following local infection control policies, such as hand hygiene practices. All staff were observed washing their hands or using the sanitisers, the latter of which were located on bed ends, at the entrance to bay areas and ward entrances.
- Staff were observed to comply with policy in respect to the handling and management of clinical and domestic waste.
- Bed linen handled was managed in accordance with best practices and sharps were disposed of safely.
- The handling and management of surgical specimens in theatres was done so in a safe manner.
- We saw surgical staff working in theatres following National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008). We observed theatre staff washing their hands prior to preparing instrumentation using an aqueous antiseptic surgical solution, and donning a sterile gown.
- We observed that if a patient needed to be shaved then electric clippers with a single-use head were used. We observed the surgeon clean the patients skin at the surgical site immediately before incision using chlorhexidine and that this area was dried by evaporation in order to avoid pooling of alcohol-based preparations. The surgical site was appropriately covered with an appropriate dressing at the end of the operation.
- We were told and reviewed evidence to support this that there was a protocol for staff to follow in respect to identifying and responding to sepsis.
- We saw Isolation signage in place where required on ward areas.
- We saw that standard operating procedures (SOP) were in place in respect to the arrangements for decontamination service providing surgical instrumentation.
- Releasing time to care performance results were displayed on wards. We saw on King's C1 and King's A2 there had not been any infections for the month up to the time of our visit.
- There had not been any Infection rates related to Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemias for April 2015.
- The clinical notes we reviewed contained evidence that demonstrated patients were MRSA screened prior to admission and on admission if they did not go through the pre-assessment pathway.
- The hospital had a dedicated infection control team, which provided support to staff five days a week.
- Matrons explained and showed evidence of how they discussed during staff reviews the environmental audits, infection rates, as well as individual IPC audits. We were able to see results for individual clinical practice audits for IPC and where environmental audits scored slightly lower than expected.

- We noted that the trust participated in mandatory surgical site infection surveillance service that occurred during the inpatient stay, on readmission and post discharge for hip and knee replacements and fractured neck of femur patients.
- Staff attended mandatory infection prevention and control e-learning every two years. We found that most staff had attended this training with a figure of 84% being given to us by the wards. We looked at individual training records to confirm this.
- We were told by patients that the ward 'was spotless'.

Environment and equipment

- William Harvey operating theatre department had eight theatres and a nine bay recovery unit. There was also a day surgery unit with four theatres, where patients were treated and cared for on trollies suitable for operating upon.
- We saw a wide range of equipment available and staff told us that they had access to the necessary equipment they required to meet peoples care needs.
- We saw that emergency equipment for resuscitation was available in each area and had been routinely checked. Oxygen and suction equipment was accessible and in date. Emergency intubation equipment checks had been carried out regularly.
- The staff we spoke to told us they had received relevant training on how to use equipment and felt confident and competent they could deal with a foreseeable emergency in their clinical areas.
- The Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis. A logbook was kept with each anaesthetic machine and saw that the daily checks had been recorded.
- We saw records that checks or servicing on equipment had taken place. This was regularly checked by the hospitals electrical equipment department.
- Staff that we spoke to told us that they had enough equipment to enable the safe and effective delivery of care.
- Single use equipment such as syringes; needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner.
- There was an electronic equipment library and nursing staff could access equipment such as intravenous infusion pumps.
- Surgical instrumentation, which required decontamination between patient use was process off site. Contaminated instrumentation was taken by a theatre support worker to a store room on the ground floor of the hospital where it was collected by the contractor for processing.

Medicines

- We made observational checks in respect to the ordering, storage, administration and disposal of medicines on surgical wards and in theatres. Staff on wards told us there was regular contact with pharmacy. Pharmacy audited medicines on a month basis. However staff told us that there were not enough staff in pharmacy. Ward staff were told if no pharmacy was available .
- We were told that a pharmacy technician came to the wards regularly but if they were unable to screen drug charts, these would need to be taken down to the pharmacy department. There was a risk that charts were away for excessive periods of time and that patients missed required medicines.
- Patients were able to self-medicate but we were told by ward staff that the proforma was not always completed before the patient began to self-medicate.
- Items which needed to be stored in refrigerated conditions or in warming cabinets were done so correctly.
- We saw documentation that showed us that temperature checks been carried out on fridges and warming cabinets on a daily basis.
- Medicine storage units were found to be locked securely and attached to walls when not in use. Intravenous fluids were not secure on King's C1 and could be accessed by anyone, as they were located in a corridor between the ward and therapist assessment room.
- We saw that controlled drugs (CD's) were stored in locked cupboards, which were secured to the wall within a locked room. We found that the CD registers of both the wards and theatres including recovery were fully completed which demonstrated good practice. Patient own CD were not always recorded correctly, for

example on King's C1 Ward, staff had not recorded on separate pages the different CD for one patient. However, the matron and sister knew what of the required process.

- We also carried spot checks on controlled drug register, storage and expiry dates and found all the areas checks to be following national guidance.
- We observed pharmacy staff checking with staff on King's B patients own CD's, which were being taken to the pharmacy department for reconciliation.
- We observed medicines being given to patients by nursing staff. We found that this was done in accordance with the prescription and that safe checks were carried out during the administration. Patients told us that staff always checked their name band and confirmed their personal details before giving them medicines.
- We reviewed a sample of medicine charts on each clinical area we visited and found them to be complete, legible and contained evidence of best practice in relation to medicines administration.
- We carried out random medicine checks in some ward areas and found all stock drugs to be stored appropriately and in date.
- Drug omissions chart were in operation, which documented the reason for the omission. One chart was observed to be difficult to read, but had already identified by the nursing staff and a request for the doctor to rewrite it was in place.
- Patient allergies had been clearly noted on Medication and Administration (MAR) charts and on their ID band.
- On one surgical ward we found that the pharmacy storage was inadequate. The medicines which were to be given to patients on discharge (TTA's) were being stored behind the nurses' station on top of a cupboard in a cardboard box.

Records

- We found records including medical records were accurate, fit for purpose, were stored securely and remained confidential.
- Patient records were paper based, with the exception of discharge letters and requests for diagnostic procedure. In the latter these were done via the electronic database. In general, nursing and medical records were completed to a good standard.
- We saw that there was multidisciplinary input where require, for example, entries made by dietitian's, physiotherapy and occupational therapists. Medical personnel also contributed directly to the records, with commentary on treatment, diagnosis and required interventions.
- We saw evidence of referral to specialist advice, such as the dietitian, tissue viability nurses and other support services.
- Patient notes contained evaluation and progress updates, as well as information in respect to discharge planning.
- We reviewed five MAR charts, which demonstrated that prescribing was in line with national guidance and that all were compliant with the National Institute for Health and Care Excellence (NICE) VTE guidance. They contained completed VTE assessments and prophylaxis had been prescribed and administered.
- Risk assessments, such as assessment of moving and handling, skin integrity, nutritional needs, use of bed rails and Venous Thromboembolism (VTE) were used to manage patients care. Where actions were required these were seen to have been carried out. For example, with respect to falls, the use of low/high beds, crash mattresses and signage to indicate closer observation was noted. We found that all patients had undergone an electronic VTE assessment as part of their admission.
- Formal care plans were not in use, but standardised pathways were followed. We asked staff how they personalised people's care and they advised that information was added to the care plan and was also included in the nurse handover form used to guide staff.
- The sample of care plans we reviewed in each area had relevant, updated and complete risk assessments in place. This included falls risk assessments and MUST(Malnutrition Universal Screening Tool).
- We observed that theatre staff fully completing the checklists based on the World Health Organization (WHO) safety procedures to safely manage each stage of a patient's journey from ward through anaesthetic, operating room and recovery.
- We saw theatre staff following the five steps to safer surgery, which included team brief, sign in, time out and sign out. Evidence of staff completing documentation to reflect the World Health Organisation (WHO) safety procedures were seen in all of the patient notes that we reviewed.

- WHO audits were carried out in theatres and day surgery on a monthly basis. We saw the results for main theatres for June 2015 with a 100% compliance score and day surgery 99.79%.
- We saw that patient records contained evidence of attendance at the pre-operative assessment where relevant. Information taken at the pre-assessment included for example, patient demographics, previous medical and surgical history, allergies, and medicines along with baseline observations. Anaesthetic risk scores were used to ensure that only those patients suitable for day surgery were admitted as such.
- Progress notes had been recorded for each patient and care plans were individualised or based on a surgical pathway, such as the hip fracture pathway. However, where care plans were not following a specific pathway they did not always have identified goals set for the patient to achieve.
- We noted 'Intentional rounding' took place at regular intervals, during which nursing staff checked the wellbeing and status of the patient and updated risk assessments if needed.

Safeguarding

- Nursing staff that we spoke to had limited understanding of safeguarding and the escalation process. We were told that they would report their concerns to the nurse in charge. They were aware that there was a safeguarding lead.
- Staff had access to a safeguarding protocol and named staff who was able to support staff in this area.
- Safeguarding training was mandatory and was provided by e-learning. On the surgical wards we saw that a number of staff had not completed both adult and child safeguarding training. For example on child protection training had been completed by 98.72 staff on King's D Ward, 91.49 on King's C2, 71.2 of staff on King's C1 and 89.16 of staff on King's B Ward. whereas in theatres 75% had completed adult and 66% of trained staff had completed child safeguarding and 84% of untrained staff .

Mandatory training

- Most of the mandatory was provided by e-learning with the exception of Basic life support and manual handling.
- Mandatory training included Health & Safety, fire, information governance and infection control.
- We reviewed the training matrix on the surgical wards that confirmed which staff had received mandatory training. We saw from performance dashboards provided that there were gaps in the achievement targets. For example, on King's A2 Ward information governance and infection control were in the red, at 67.65 and 71.57 respectively. Other training which had not been completed by relevant staff included child protection and equality and diversity. Similar gaps were also noted for King's B, and King's C1.
- Within the theatre department we found that Health & Safety training had been completed by 62% of staff and manual handling by 59%. Within theatres all training was monitored and booked by the learning and development facilitator. We were informed that there had been problems with the e-learning platform which had impacted on their on-line training compliance. This was said to have been rectified and an action plan was in place to improve completion. We also were informed that on every educational day, which were held every two months there would be manual handling update sessions which staff would have to attend.
- The staff we spoke to told us that their training needs were continuously met and that if they required extra training that it was provided.

Assessing and responding to patient risk

- Nursing staff described the use of an early warning scoring system, which was used to monitor patient condition following their surgery. The scoring system enabled staff to identify concerns before they became serious and to get support from medical staff. We saw the early warning system in use in patient notes reviewed.
- The care plans we reviewed demonstrated that the early warning monitoring system, know as 'ViEWS' was being used appropriately, and care pathways contained an audit trail of actions taken by staff when the patient's condition required escalation.
- We were told by nursing staff that when a medical review was necessary that the surgical team and consultants were responsive in reviewing patients, and we saw this was the case from records reviewed.
- The surgical department had embraced and fully embedded the WHO (World Health Organization) safer surgery checks and the trust could demonstrate an audit cycle to reflect its use and identify any shortfalls.

- We observed the theatre team using the check list during the inspection and saw audit results that showed a 100% compliance.
- On the trauma and orthopaedic ward we saw evidence of physiotherapy assessments in respect to patient mobility displayed in each patient bed area. This ensured that staff were aware of mobility risks.
- We saw that a sepsis pathway was in place.
- There is a dedicated emergency theatre that was available all day and every day. We found that only seriously ill patients were operated on at night in line with the Royal College of Surgeons Unscheduled Surgery Guidance.

Nursing staffing

- From our observations, the rotas we viewed and the conversations we had with staff we found an appropriate staff numbers and skill mix in clinical areas.
- The hospital used a staffing acuity tool that monitored staffing levels on a daily basis and took patient's conditions into consideration. This helped to ensure that clinical areas were appropriately staffed.
- Staffing was reviewed at a senior level, usually by the matron on a daily basis or more regularly if the service indicated a change in acuity or identified pressures on service delivery.
- Staffing figures were displayed on each ward. These indicated the optimum and the actual staffing levels for each part of the day and night shift.
- There was a designated person in charge each part of the day/night.
- The staff we talked with told us that they felt these were enough staff to meet peoples care needs.
- We noted from rotas viewed and conversations with staff that every effort was made to offer permanent staff unfilled shifts to promote continuity of care. When this was not possible agency and bank staff provided cover.
- Theatres used agency to fill the more specialised roles.
- Agency and bank staff completed an induction prior to working at the hospital and records of the induction were viewed during the inspection.
- Nursing staff participated in regular handovers to ensure that patients care needs were discussed to ensure effective continuity of care.
- We attended a nursing handover arrangements between the night to day staff shift. Detailed information was provided with respect to each patient, including risks, treatment and care, results of investigations. Where referrals were made to specialist expertise, such as dietitian's, tissue viability, diabetic nurse, this was explained. Patient status regarding mobility and progress was discussed in addition to discharge arrangements.

Medical staffing

- Medical staff skill mix for the surgical directorate across the locations was 315 whole time equivalent (WTE) as of September 2014. This was made up of England comparable levels of consultants at 40%, slightly higher levels of middle grade doctors, at 16%, against England average of 11%. Middle grade doctors have at least three years at senior house officer or higher grade within their chosen speciality. Registrar group made up 30% of the medical workforce, against an England average of 37%. Junior doctors in foundation years one or two contributed 15% of the medical staff, against England average of 13%.
- There were 10 consultant surgeons, nine middle grade doctors, six core trainees and nine foundation grade doctors attached to surgery division.
- We were told that there was consultant cover everyday including weekends. Consultants saw new admissions which were accepted over night, patients who were unwell but under the care of other medical staff, and reviewed their own patients. There were on-call arrangements out of hours, including ad-hoc cover on bank holidays.
- The junior doctors we spoke with during the inspection told us they felt there was enough doctors to meet peoples care needs.

Major incident awareness and training

- There was formal guidance available to staff with respect to the actions to be taken in the event of a major incident. Signage indicating where staff could access the protocol was displayed on wards. We saw too in the signage that dates had been provided for training.
- There was a local policy for Major Incident and Mass Casualty Incident Response Plan, which included for example, cascade, patient flow and internal support services.
- There was a protocol in place for managing in-patient theatre emergency bookings through the emergency theatre.
- Staff told us that they had recently received major incident training and were able to talk to us about this.

Surgery

Are surgery services effective?

Requires improvement

We found the care delivered in the department to be evidenced based and adhered to national and best practice guidance. The care delivered was routinely measured to ensure quality, adherence to national guidance and improve quality and patient outcomes. The trust was able to demonstrate that it was continuously meeting national quality indicators.

The hospital had a dedicated pain team that provided specialist pain services to patients. The patients we spoke to told us that pain medicine was administered in a timely fashion and that they were satisfied with the way their pain was managed.

Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. Staff received an annual performance review and had opportunities to discuss and identify learning and development needs through this.

Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through the multidisciplinary team and specialists

Mental capacity and Deprivation of Liberty Safeguards (DoLS) was not understood by all staff. Consent was fully understood by staff and documentation was fully completed.

The nutritional needs of patients were assessed and patients were supported to eat and drink where their needs indicated. There was access to dietitian's and the speech and language therapy team. Special medical or cultural diets were catered for.

Patient surgical outcomes had been monitored and reviewed through formal national and local audit.

Evidence-based care and treatment

- We reviewed data and patient notes seen during our inspection that patient's treatment and care complied with National Institute for Health and Care Excellence (NICE) guideline CG124: Hip fractures – The management of hip fractures in adults. This included for example patients being operated on the day of or day after admission and having a bone health assessment.
- We saw from care records reviewed and found in our discussion with staff they were following NICE guidance on falls prevention, the management of patients with a fractured neck of femur, pressure area care and venous thromboembolism. We saw that anti-coagulant therapy was prescribed for patients at risk of the latter and anti-embolic stockings were measured and fitted to respective patients where relevant.
- Patients who attended pre-admission assessment were having pre-operative investigations and assessment carried out in accordance with NICE clinical guidelines. This included following guidance regarding medicines and anaesthetic risk scores.
- Staff followed procedures to ensure patients receiving post-surgical care were nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. This included recognising and responding to the deteriorating condition of a patient and escalating this to medical staff following the early warning alert system.
- Within the theatre areas we observed that staff adhered to the (NICE) guidelines CG74 relating to surgical site infection prevention and nursing staff followed recommended practice in respect to minimising the risk of surgical site infections. There was a sepsis pathway to follow where patient's needs indicated.
- Surgical site infections were monitored and reported to Public Health England. The incidence of surgical site infection for repair of neck of femur (inpatient and readmission) at William Harvey Hospital was above the national 90th percentile at 4.5% for the period January to March 2015. A proposal to address this was provided to us and was to be presented for consideration by the divisional governance board.
- We observed staff following local policies and procedures in respect to patient manual handling and interventional rounds. In theatres we saw staff followed safe practice in respect to swab and needle counts, as well as surgical instrumentation. We observed the patient journey through into the operating theatre and saw staff complied with WHO safety checks at each stage.

- There was evidence in the care plans and notes we reviewed to demonstrate compliance with local hospital policies.

Pain relief

- Ward areas had access to a pain team if required and we were told that requests were actioned quickly. The pain team was available by way of an on-call system at night.
- We observed that there was consideration of the different methods of managing patient's pain in use, including patient controlled analgesia pumps.
- The hip replacement protocol included directives around pain management .
- Pre-operative assessment included information about the patient in respect to existing pain management, such as the medicines they took. Pain relief was noted to be prescribed for patients.
- The hospital used appropriate pain scoring tools to assess adult pain levels. ain levels were assessed pre and post operatively if applicable. The Day Surgical Unit (DSU) used an appropriate pain scoring tool to assess pain levels.
- Patients in the DSU were prescribed and dispensed pain medication before leaving the department
- Patients confirmed in their discussions with us that they had been asked about their pain and had been given pain relief. We observed in care records reviewed that there was a pain score assessment in use and this was completed to a good standard.
- Patient experience feedback monitoring was reviewed by us and we noted from the June 2015 figures that satisfaction with pain control scored well across all surgical wards, with scores between 93 and 96.
- Patients received appropriate information on discharge detailing how to manage their pain.
- Patients told us that they were unhappy as they were having to wait along time in order to get their discharge medicines, which included pain relief to take home.

Nutrition and hydration

- The nutritional needs of patients had been assessed by nursing staff as part of the initial assessment, as well as when their circumstances changed. Malnutrition risk scores were used to indicate the level of support required. Where patients needed help to eat staff assisted them.
- We looked at menus and found that a variety of meal choices were available including those patients with special needs including low-fat, diabetic and gluten free.
- We found that re-admission assessment included dietary plans for Bariatric patients and colorectal patients.
- Fluid balance charts were in use where appropriate and used to monitor the patient input and output. This included for intravenous fluids.
- Risks assessments were in place for patient's nutritional needs and were reviewed as part of the patients progress report.
- Patients' weights were recorded on admission and monitored to identify any weight loss during their hospital admission. These were evidence of good clinical practice on the wards with the majority of patients being weighed

Patient outcomes

- Relative risk of re-admission performance for elective surgery procedures was slightly above the England average, with trauma and orthopaedics accounting for the majority of these, at 138 against 100. Patients having ear nose and throat (ENT) and general surgery accounted for very small risks of readmission.
- With the exception of trauma and orthopaedics, the relative risk of readmission for non-elective surgery was less than the England average.
- Patient Reported Outcome Measures (PROMS), which were responses from a number of patients who were asked whether they felt things had 'improved', 'worsened' or 'stayed the same' in respect to four surgical procedures at the trust. Patient self-reported health outcomes for groin hernia, hip replacement and knee replacement were less than England average. The Oxford knee score indicated above England average for improvements in patient condition.
- Six out of nine comparable standards in the hip fracture audit for 2013 and 2014 were better than the England average at William Harvey Hospital. This included for example, 97.6% of patients having a senior geriatric review within 72 hours of admission, 97.6% of patient shaving an abbreviated mental test carried out, and 99.8% having a specialist falls assessment performed. The location scored less well on being admitted to an orthopaedic ward within four hours, at 33.1%, against an England average of 48.3%.

Surgery

- In relation to the National Emergency Laparotomy Audit for 2014, William Harvey Hospital was compliant with 12 of the 28 standards. For example; having a fully staffed operating theatre for emergency patients 24/7, contemporaneous CT reporting 24/7, a formal rota for on-site interventional endoscopy and critical care outreach 24/7. Other areas of good practice related to a sepsis pathway, formal handover between surgeons. Areas less satisfactory related to the lack of enhanced recovery pathway, policies for anaesthetic and surgical seniority and a lack of policy for deferment of elective patients to prioritise emergencies.
- The trusts results for the National Bowel Cancer Audit for 2014 indicated that 100% of patients were discussed at a multi-disciplinary meeting but, that only 1.4% were seen by a clinical nurse specialist, against an England average of 87.8%. The CT scan was only reported on in 0.6% of cases, compared with 89.3% England average. The low rates for these two areas may have been as a result of inaccurate reporting.
- Lung Cancer Audit results for the trust in 2014 indicated that out of the 456 cases, 95.4% were discussed at a multi-disciplinary meeting, which was almost comparable to the England average of 95.6%. The percentage of patients receiving CT prior to bronchoscopy and surgery was below the England average at 85.6% and 13.6% respectively.
- There was evidence that the surgical division followed the Royal College of Surgeons standards for unscheduled care, which included having consultant led care, prioritising the acutely ill patient and ensuring that preoperative, perioperative and postoperative emergencies led to appropriate outcomes.

Competent staff

- A system for annual appraisals of staff was in place. We saw records that demonstrated staff had received annual appraisals. Within main theatres 72% of staff and DSU 75% had received an appraisal. We were told that a Band 7 meeting had taken place the week before our inspection and that an action plan had been made in order for them all to be completed. On the surgical wards we found that all staff were up to date with their appraisal.
- Surgical wards and theatres had Preceptorship and mentoring arrangements in place to support new staff.
- We saw that all staff were given a local induction to the clinical area and also had an induction checklist to complete, this also included agency staff.
- Theatre had competency books for registered and non-registered staff to complete. This contained generic competencies for each area of theatre, patient collection and recovery. This book was then 'topped-up' with specialist competencies for each surgical speciality such as gynaecology or general surgery. These competency books were reviewed regularly by the learning and development facilitator.
- Surgical wards also had generic competencies for staff to complete with a three to six month completion deadline.
- Discussions with therapy staff indicated they were knowledgeable and highly trained.
- A student nurse told us that they had been orientated to the ward, including evacuation plans, ward structure and other relevant information. They had a mentor, who they were working with. They were undertaking various competencies, which had been discussed and agreed for the period of their placement on the ward.
- Some staff had additional responsibilities as link nurses. For example, tissue viability or infection control link nurses and these staff also provided updates to the clinical area after attending meetings.
- Junior doctors reported to us they were well supported clinically at senior level and that teaching was at a regular time and was good.

Multidisciplinary working

- We observed very positive and proactive engagement between members of the multidisciplinary team.
- We attended the trauma meeting, which was very well attended by a range of staff including, consultants, radiologists, junior doctors, the trauma co-ordinator, consultant orthogeriatrician, matron and nurse practitioner. There was detailed discussion of patients, which covered progress, pre-planning of surgery for later in the week, additions to the day's theatre list. The session was run as an interactive and educational opportunity that followed the needs of the patient.
- We observed a board handover on King's C1, which was a multidisciplinary discussion and review of patient progress. Discussion included arrangements for discharge and progress where delays in discharge were being affected by external difficulties, such as funding for nursing homes.

Surgery

Seven-day services

- There was access to one emergency theatre at all hours.
- Consultant cover was available seven days a week. This meant that consultants were on site from 8:00am to 5:00pm and an on call system operated out of ours and at weekends.
- All new admissions were seen by a consultant within 12 hours of admission.
- Nursing staff told us that medical cover at weekends was appropriate and accessible.
- Scheduled theatre lists ran on Saturday and Sunday. Services were agreed with radiology, pathology and pharmacy.
- Theatre staff had access to theatre utilisation, on-time starts and the total number of operations carried out on a monthly basis. This was in poster form on a staff notice board.
- Physiotherapy - On call was provided from 4.30pm to 8.30am Monday to Friday and from 8.30am to 8.30am Saturday and Sunday. This was primarily for emergency respiratory patients. A limited seven day service was provided to T&O patients at WHH, which was primarily for elective patients and fractured neck of femurs. At WHH the service was funded for four hours on a Saturday and six hours on a Sunday
- Out of hour's pharmacy service availability was arranged as follows: Saturday and Sundays 9am until 12midday, with on-call outside of these times.
- Microbiology operated a 24/7 service, on-call OOH, Cellular Pathology operated a six day week, as there was no demand reported for 24/7, and Blood Sciences 24/7 through the continual pathology service.
- Radiologists, CT and X-ray were available 24/7 for emergency work.

Access to information

- Ward staff said they attended ward meetings when able and that urgent information would be communicated at handover.
- Theatre staff received information at theatre 'briefs' and 'debriefs' as well as at departmental meetings.
- Staff told us that most information was available on the intranet. They also reported having access to information and guidance from specialist nurses, such as the tissue viability nurse.
- There was access to literature both on the hospital website and in departments. A patient in the day case unit confirmed that they had been given sufficient information about their treatment and care by the surgeon.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients that we spoke to told us that they had been given information about the benefits and risks of their surgery prior to signing the consent form in a clear manner. They had been able to ask questions if they were not clear on something.
- We found that there was very little understanding about mental capacity and Deprivation of Liberty Safeguards (DoLS) amongst the nursing and theatre staff.
- Mental Capacity Act training was part of the Safeguarding Adult training. No training on Deprivation of Safeguards (DoLS) was provided.
- We saw that consent forms were fully completed containing no abbreviations so that patients could easily understand what had been written.
- Consent forms identified all of the possible risks and complications following the procedure.
- Physiotherapy staff had a good understanding of mental capacity and how to have this assessed. They were aware of Independent Mental Capacity Advocate's (IMCA's).

Are surgery services caring?

Good

The patients we spoke with during the inspection told us that they were treated with dignity and respect and had their care needs met by "kind" and "caring" staff.

We observed patients being treated in a professional and compassionate manner by staff. The staff we talked with told us that they enjoyed their work. Staff also spoke about being dedicated to delivering good quality patient care.

Patients reported feeling involved in planning their care and told us they received enough information about their conditions. The hospital had a number of specialist nurses who were able to provide emotional support for patients and make referrals to external services for support if necessary.

Surgery

Compassionate care

- The average response rate for the Friends and Family Test for the period December 2013 to November 2014 indicated a 36% response rates, which was above the England average of 31.7%. Average response rates by ward varied from 37% on King's C1 up to 55% on King's A2. The highest response rate was from the Rotary Suite, which was the head and neck ward.
- Communications observed by us were seen to be friendly, with explanations being given to patients regarding any care that was going to be delivered to them.
- We were told by a patient that "I feel like they are on my side which is a big thing as a patient as it gives you confidence".
- We observed the interactions of staff in all areas visited and saw evidence that staff were knowledgeable, competent and compassionate in their administrations. We observed staff treating patients with dignity and respect.
- Patients were spoken to in a respectful and caring way, with staff affording them time to have their questions responded to or information provided.
- Communications between staff were noted to be open and enabled discussion of patient needs in order to achieve the best outcomes.
- Patients were able to express their views, so far as they were able to do so and were informed in making decisions about their care options.
- Patients had call bells and nursing staff responded promptly to these.
- We followed a patient journey to the operating room and observed that the patient's anxiety was alleviated by an operating department practitioner, who spoke in a kind and reassuring manner to them.
- We observed a patient with a cognitive impairment, exposing themself; nurses realised and very quickly covered her to protect her dignity.
- We were told by a ward clerk that "they are a great team up here, they really do care about what they do".
- Patients told us that " I couldn't have had better treatment" and that "everyone has been so nice".

Understanding and involvement of patients and those close to them

- We were told by a patient that " I don't feel that there's anything that I am not involved in" and" I had enough time with the doctors and they talk to me about how I'm doing".
- Patient experience information that was provided to us indicated red rated scores for King's B, C1 and D for June 2015. The scores related to patient involvement and achieved less than 80 satisfaction.

Emotional support

- Patient admission assessments included information about their psychological wellness and any previous issues which would need to be considered within their treatment and care
- Staff confirmed there was access to clinical nurse specialists, including the enhanced recovery nurse, and stoma care nurses, as well as the colorectal nurse and the palliative care team.
- We saw evidence of behavioural assessments having been carried out, as well as the assessment of individuals psychological and emotional needs, particularly where patients had needs associated with living with dementia.
- A patient explained to us that when he was experiencing emotional difficulties, the staff spent time to talk to him to find out the difficulties. They respected his need for space, balanced it with supporting his emotional well-being by gently and appropriately encouraging him to talk or being involved in the day socially.
- Worries and fears of patients had been monitored through patient experience feedback. We saw from the June 2015 figures provided only two wards (King's A2 and C2) achieved a green rating of above 90. All other surgical wards scored above 80, achieving an amber rating.

Are surgery services responsive?

Requires improvement

The surgical assessment unit provided rapid investigations, treatment plans and diagnosis for patients who were referred to the service by their GP, but this had restricted opening hours. The pre-admission service was well organised with access to consultants as necessary.

Surgery

Referral to treatment times were not always met. Patients experienced delays in their discharge from hospital due to their take home medicines being delayed by pharmacy.

There was a delay in patients being transferred from theatre recovery to a post-operative ward and also recovery received on occasions intensive care patients due to lack of capacity in the unit.

Complaints were acknowledged, investigated and responded to. However, sharing of information regarding complaints was not in evidence within the theatre department.

Service planning and delivery to meet the needs of local people

- The majority of surgical activity at William Harvey Hospital (WHH) was predominantly day case work, at 43%. Elective surgery contributing 22% of activity and emergency surgery 35%. Trauma and orthopaedics was the highest area of activity, at 36%, followed by general surgery, at 24%.
- There was a wide range of surgical activity, both general and specialised to meet the needs of the local population. This included colorectal, breast surgery and joint replacement for example.

Access and flow

- Access to surgical services was via A&E or GP referral to the Surgical Assessment Unit during its opening hours of Monday to Friday 10am to 6pm.
- The Surgical Assessment Unit provided access to early Ultrasound and CT services and review by the registrar on call. Patients were then either discharged or admitted for further investigations or surgical intervention.
- There was provision for pre-admission assessment which ran Monday to Friday. This was nurse led but with access to anaesthetist and consultant as necessary. The pre-assessment was valid for six weeks prior to the planned procedure. If surgery was delayed after this time then the patient would be seen again by pre-assessment.
- Referral to treatment (RTT) percentages within 18 weeks, admitted adjusted, was below the standard of 90% between March 2014 and February 2015.
- Referral to treatment time (RTT) for Ophthalmology, Thoracic Medicine and Urology met the 90% standard, whilst ENT, general surgery and trauma and orthopaedics did not.
- The percentage of patients whose operation was cancelled and were not treated within 28 days was lower than the England average in seven of the eight quarters for 2012/13 to quarter three 2014/15.
- Average length of stay (LOS) for the top three surgical specialties was less than the England average for elective surgery, with the exception of ENT, which was 7.5, compared with England average of 6 days. For non-elective surgery the average LOS was less than England average in the top three surgical specialities.
- Main theatre utilisation for June 2015 was 89.7% and in DSU was 78% against a target of 85%.
- We found from data provided that 76% of patients had their surgery on the day or day after admission, against an England average score of 73.8%.
- Medical staff reported that the emergency CEPOD theatre was accessible when required.
- Patients attending the DSU were pre-assessed in accordance with guidelines. Any concerns were identified and if necessary the patient was referred to the consultant anaesthetist who reviewed the notes on a weekly basis. There was also a duty anaesthetist on site who could be approached to review the patient.
- Discharge arrangements were commenced as soon as possible in the patient journey. Staff reported that the discharge process caused them the most problems, particularly where a person needed rehabilitation and funding to support their on-going care. There were delays in obtaining take home medication, which contributed to delayed discharges.
- The care of surgical outliers was overseen by speciality consultants and such patients were identified at ward level and within bed management meetings.
- We observed that one of the wards was being used as a corridor to another ward area and that storage was a problem. The traffic to the other ward, and the storage of chairs, hoists and other equipment, ward rounds and domestic activity meant that getting from one bay to another was difficult in the early part of the morning.
- We were told that the SMART cards were required in order to access computer records and information worked intermittently and therefore caused access to information issues.
- We were told that patients in recovery were spending more time there than required due to postoperative bed issues.

Surgery

Meeting people's individual needs

- There was good ward staff awareness about patients who were living with dementia and how their needs may have required a different approach.
- Translation services were available but needed to be arranged ahead of time.
- The Orthogeriatrician was said by staff to review elderly patients on a daily basis.
- Staff who spoke with us about patients with learning disabilities described how they would take care to ensure their communications were appropriate. They told us they would encourage a carer or relative to be present, especially when having to explain treatment.
- King's C3 was a fracture neck of femur ward and therefore cared for a high number of people with dementia related needs. The staff had started to make arrangements to address the needs of patients who were living with dementia. A room had been designated for therapy, which was called a "Rem Pod". Items of reminiscence for patients to use were located in this room, for example, a radio, china cups and saucers, and a selection of locks and switches. However, we saw that the 'Rem Pod' was also being used as staff room and for general meetings, as well as pre-discharge assessments by physiotherapy and occupational therapists and was therefore not always accessible to patients.
- There was a Health Care assistant (HCA) on the ward who was the lead for the 'Rem Pod' and for coordinated the activities.
- There was a Mental Capacity Act (MCA) board on the ward, that identified the steps that staff needed to take if they suspected that someone lacked capacity. However staff were unable to tell us anything about the mental capacity act.
- The wards had a dementia matron who provided support for the wards.

Learning from complaints and concerns

- Staff that we spoke to could tell us of the complaints reporting and investigation process.
- We saw that information about the complaints procedure was available in ward areas. This included information about the Patient Advice and Liaison Service (PALS), which was available to patients
- We were told by patients that they knew how to complain and felt confident in raising concerns and complaints.
- Staff were aware of the reporting process for complaints and said they had feedback where it related to the ward or their practice. For example a patient had complained that he felt intimidated by staff on the ward who talk in their own language when they group together. This resulted in it being highlighted to all staff that all communication must be made in English at all times when they were on duty.
- Complaints information provided to us for the first quarter 2015 indicated there had been seven formal complaints in April, three in May and two in June for the surgical wards. There had been 799 compliments for the same period.
- Within the operating theatre department there was no evidence of any discussions or communication of incidents or complaints.

Are surgery services well-led?

Good

The trust operated an effective governance structure. The departments risk register demonstrated that risks were identified, recorded and actioned appropriately as well as ensuring a transparent audit trail of the risks identified.

Senior leaders understood their roles and responsibilities and were committed to overseeing the standards of service provision in all surgical areas. The senior leaders had a clear direction of focus underpinned by the values of the trust.

Staff reported a new effective leadership culture with the aim of feeling valued and respected.

Patients and staff were encouraged to contribute to the running of the service, by feeding back on their experiences and sharing ideas.

Vision and strategy for this service

- All staff that we spoke to were aware of the trust's vision and could discuss it with us.
- The surgical division directors oversaw the surgical services across the three locations and recognised the challenges this presented, particularly with respect to medical staff rotas. They told us they were working to develop a clinical strategy for the future, which would promote the delivery of services over the three hospitals. We were told the corporate strategy had been

worked on for the last year, using a hub and spoke approach; however, the financial position had meant the focus had needed to change. The senior clinical anaesthetist was taking the lead on engagement within the division to identify the most optimum pathway for electives and non-elective patients before the strategy could be presented to the trust board.

- We reviewed the draft strategic briefing document for the surgical division, 2015/16. This set out the short, medium and longer term plans, with a view to providing a service that met the current and future needs of the local population. During 2015 and beyond the strategy was to be presented to the public for consultation by the divisional clinical leads.
- There was no awareness of the surgical strategy when we raised this question with nursing staff.

Governance, risk management and quality measurement

- The terms of reference for the surgical services clinical governance board set out the membership and purpose of the board. A divisional governance matron had been appointed in March 2015 and they were supported by band 6 managers to deliver the required data, which was now more robust and included complaints, action after review, incidents and learning. The latter data collection monitoring was only in its infancy, having started at the end of May, early June. A designated medical lead had responsibility for governance and patient safety, risk management and quality measurement.
- The surgical services clinical governance board meetings were taking place monthly on a Tuesday morning between 9am and 11am and that they rotated around the three sites.
- Individual surgical specialities had started to be invited to monthly governance meetings and were expected to present a summary of the performance dashboard from a clinical view.
- We reviewed the risk register and saw there had been thorough analysis of potential and actual risks which related to the surgical divisions.
- Staff received trust news containing information along with their wage slip.

Leadership of service

- Staff told us that the Director of Nursing visited the clinical areas and that she was very open and supportive.
- There was a new senior management team in place and the new Chief Executive had visited all clinical areas in order to introduce himself to staff of all grades to reiterate that staff could contact him directly if they had a concern. Staff were able to discuss with us the high level management changes that had happened over the past six months.
- Matrons were visible on the wards and staff told us that " we can go to the matron for anything e.g. when there were difficulties on the ward last week I called the matron out of a meeting".
- Within the theatre department there was a general manager, which freed up the matron in order that she could lead on clinical care.

Culture within the service

- We were told by staff that they did not get the rationale for changes that they were told to introduce. " I feel sometimes they go off and know everything. Feels like we are not privy to information".
- Staff held the general view that they liked working for the trust. They believed that the quality of care provided was good.
- We were told by theatre staff that there was now open communication between staff of all grades including managers and that things were improving.
- We were told by staff they felt valued and respected within the hospital.
- Staff well-being was monitored. For example, we saw information which monitored staff sickness absence. King's A2 ward had 4.19% sickness for the period July 2014 to June 2015. King's B sickness rate for the same period was 4.03% and King's C1 was 5.38%.

Public and staff engagement

- Staff engagement in surgical areas was encouraged by initiatives for staff for example the newly set up Quality Innovation and Improvement Hub. This gave staff the opportunity to express views, and see the actions and responses that had been taken as a result.
- Healthwatch undertook engagement activities at the request of East Kent University Foundation Trust. They sought public feedback on the current services which were provided by the trust.

Surgery

Innovation, improvement and sustainability

- An 'improvement hub' had been set up, which provided staff with a forum in which to share information, receive feedback and make suggestions for improvements to services and care.
- We saw numerous examples of comments made by staff and responses to these, which demonstrated open and honest communications.

Critical care

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

Information about the service

The William Harvey critical care unit provides care for adults. Patients who have a potentially life-threatening illness or injury can be admitted to an intensive care bed where they receive one-to-one nursing care (level 3 care). Patients who are too ill to be cared for on a general ward but do not need an intensive care bed can be admitted to a high dependency bed (level 2 care). The unit currently has a total of eleven beds, eight level 3 beds and three level two beds. Two level two beds were opened to meet service demands placed on the service in 2013 and have remained in operation. A critical care outreach team provided a trust wide service twenty four hours a day.

In order to undertake the inspection we spoke to 7 relatives, 2 patients and 15 staff. We reviewed documentary evidence from a range of sources as well as engaging with external stakeholders and members of the public to reach a judgement on whether the service was safe, effective, caring, responsive and well led.

Summary of findings

We found the service delivered at the William Harvey Hospital Critical Care Unit (CCU) to be safe, effective, caring, responsive and well led.

However, we continue to recognise a concern with delayed discharges from the unit which may suggest problems with patient flow elsewhere in the hospital. Capacity in the unit was also a concern, given the 100% occupancy rates despite the additional two unfunded beds in operation. The location of these beds was not desirable but staff had taken reasonable steps to minimise the risk to patients and staff.

We also noted a robust strategy and vision in the unit, but were uncertain about whether it reflected the trust vision. We acknowledge a recent change to the trust leadership, and the ongoing financial challenges, which presented an obstacle to achieving the plan. We recognised the frustrations of staff in terms of the stagnant situation in which they find themselves due to the environmental and financial restraints. The CCU did not always manage to achieve the national recommendation of ensuring a supernumerary shift leader for all shifts. However, we acknowledge that there has been a significant improvement in supernumerary management cover since our last inspection.

Critical care

A standardised approach to inotropic infusion concentrations (modifies the force of muscle contractions) and meeting national guidance for the x-ray checking of Nasogastric (NG) tubes had been implemented across all three sites.

We found effective systems in place to ensure safe care. The care delivery was continuously monitored and assessed to ensure a high quality care for the patients using the service. There was a positive culture towards reporting and learning from adverse events, and a refreshingly positive emphasis put on avoiding recurrence.

The care delivered reflected best practice and national guidance, with the exception of inconsistencies trust-wide in the application of a standard operating procedure for the placement of nasogastric (NG) tubes. Needs were risk assessed and the unit could demonstrate a track record of delivering harm free care. There were appropriate measures in place to ensure that patients were protected from the risk of acquiring hospital acquired infections, and staff were observed to follow trust infection control guidance.

Patients and their loved ones had their dignity and human rights respected and protected. The unit provided an ample and varied supply of information for relatives, and actively encouraged their feedback and comments. If a complaint was raised the service learned from the feedback given, and ensured that people felt listened to.

The relatives we talked with during the inspection were very complimentary about the service their loved ones had received, and the caring and approachable attitude of the staff. Relatives were also involved in the planning of care and told us that they had access to sufficient information about their loved ones' condition. Patients had their right to consent to care respected and, where possible, formal consent was obtained. Staff were found to make reasonable adjustments to reflect the needs of their patients. The service provided a person centered bereavement service for families.

There were suitable arrangements in place for dealing with foreseeable emergencies. Patients had their health needs risk assessed and balanced with safety, and had their rights and preferences taken into consideration.

We noted effective systems to ensure patients' nutritional and pain needs were addressed and managed. Medication management reflected national and trust guidance.

The CCU had appropriate numbers of staff with the required skills to meet people's individual care needs. Staff were subject to competency-based learning and assessments, and were provided with support to learn, develop and progress professionally.

A multidisciplinary approach to care was noted, as was the provision of a seven day service. There was a consultant-led ward round twice daily which meant that patients conditions and progress were continuously monitored. There were effective systems in place to ensure that deteriorating patients had their care needs reviewed in a timely manner. This was also true of patients who were in ward areas as they had their conditions reviewed by the outreach team using an electronic monitoring system.

There was strong leadership in the CCU and staff expressed feeling valued and listened to. They voiced satisfaction with the local unit management and the support provided to them. Numerous steps had been put in place to address the culture concerns raised in the last inspection. Staff told us these measures had a positive impact on morale and on their working environment.

Critical care

Are critical care services safe?

Requires improvement

We found the safety of the service delivered in the CCU to require improvement This relates primarily to the lack of compliance with NICE and National Patient Safety Agency (NPSA) guidance for the use of x-rays inconfirming NG tube placement. Although incidents relating to this had beeninvestigated, there was a lack of evidence that learning had been disseminated to all units in the trust. This had resulted in avoidable risks to patients being poorly managed..

The critical care environment was not meeting the national standards for critical care units. The space between beds was inadequate which created a risk to patients, for example in terms of infection control prevention. This also impacted on staff's ability to provide care and adhere to health and safety regulations when extra large medical devices or equipment was required to provide care. The unit had implemented two extra beds to improve capacity, however, the geographical location of these two beds also posed a risk to patient and staff safety as they were located away from the main unit. Whilst we recognise the staff had undertaken the appropriate risk assessments and put measures in place to reduce the identified risk, the situation was not sustainable in the long term.

Inspectors found that there were effective systems in place to learn from adverse events, incidents, errors and near misses which occurred within the service.

The service demonstrated meaningful engagement with Mortality and Morbidity (M&M) processes, which was clearly evident in meeting minutes and conversations with staff. Outcomes from these meetings were escalated via the appropriate safety and risk processes. However, the inspection identified concerns that incidents which related to other clinical areas were not always as involved in the learning from M&M's, for example A&E.

Safety thermometer data was collected and collated and used to improve and drive service change. Data was displayed in a public area which meant it could be easily accessed by interested parties.

The unit was found to cleaned to a high standard and regular audit demonstrated compliance with national guidance. Staff were observed adhering to trust infection control policy and there was ample supply of PPE (Personal Protective Equipment) available for use. There was an appropriate level of infection control audits in place to monitor the standard on the unit.

The unit had procedures in place to ensure the safe storage, handling and management of medicines. Documentary evidence demonstrated that patients received their medicines in a timely manner and reasons for omission were clearly documented. Pharmacy support was provided to ensure regular reviews and internal audits.

The medical records we reviewed were found to be in good condition, easily accessible and stored securely and effectively. Staff received appropriate levels of training and support to be able to provide support to patients. We found sufficient levels of staff to deliver safe care with the support of agency staff. Three additional intensivist consultants (a physician who specialises in the provision of intensive care) had been recruited and were due to join the unit in October 2015.

There was an appropriate major incident plan in place. Staff were able to tell inspectors of their roles and processes to follow should a major incident occur.

Incidents

- We found appropriate systems for gathering, monitoring, recording and evaluating accurate information about the quality and safety of the care and treatment delivered on the unit.
- There were also systems in place to reduce the risk of patients receiving unsafe or inappropriate care.
- Incidents were being reported, investigated and learned from on the critical care unit (CCU). We were shown evidence that indicated RCA's (root cause analysis) investigations were carried out when required. In our conversations with staff and our meeting minutes we saw that these investigations had been learned from.
- Matrons manage risks and incident reporting, and the process is overseen by the consultant nurse. Feedback from incident reports is fed into a multidisciplinary critical care steering group and the surgical division governance board.
- The unit operated an effective risk register where the risks in the service was documented and appropriately

monitored once identified. The register was reviewed regularly and there was evidence that concerns were escalated to senior trust management via the governance, safety and risk pathways available.

- There were three risks identified as high - two related to equipment and one to CCU capacity concerns. In an attempt to address the capacity issue the trust has provided two additional beds on the William Harvey site, however these beds remain unfunded and away from the main unit, which increases the clinical risk to patients. Senior staff had undertaken the appropriate risk assessments for the additional risk, and steps were in place to minimise the risks identified with the extra beds in the interim, however the situation was not sustainable long term. Risks in the service were identified, addressed, monitored and escalated when necessary which meant that risk in the service was being appropriately managed.
- The critical care unit reported no never events (A never event can be defined as a serious incident that is considered preventable) in the last 12 months.
- The unit held regular Mortality and Morbidity (M&M) meetings. M&M meetings can be defined as a meeting established across the NHS to review deaths and to learn from complications and errors as part of professional learning, and to provide the hospital board with the assurance that patients are not dying as a consequence of unsafe clinical practices. The meeting minutes we reviewed, and the conversations with staff, demonstrated that this process was effective and that learning was passed through the unit. However, we did note that where an incident occurred which involved another area in the hospital the dissemination and learning could be much improved. For example, the minutes we reviewed identified concerns which related to A&E. The CQC A&E inspection team asked senior staff in A&E if they were aware of the outcome or learning from the CCU M&M reviews. Staff told us they were not aware of the learning or recommendations to prevent recurrence and improve care.
- A global trigger tool was in operation on the unit. This meant that 20 sets of medical records every month are audited and reviewed to identify adverse events and to identify trends and themes across disciplines. Feedback from the audit is presented at team meetings and escalated to patients safety board.
- The unit used an electronic incident reporting tool (Datix) to report incidents in the clinical area. We saw evidence that these incidents were reviewed in a timely manner and had actions and outcomes clearly documented. The staff we talked with were able to provide us with examples of trends and themes and learning actions from the reported incidents. Junior nurses received training and were encouraged to take part in Datix coordination.
- The staff we talked with were able to tell inspectors about the new Duty of Candor regulations and the implication the new regulations had on their clinical area. This meant that staff were informed on the recent changes to the regulations, and their duty to be open and candid in their approach to the service they deliver.

Safety thermometer

- We found the unit collected data to demonstrate that it was meeting the needs of its service users.
- Safety thermometer data was being routinely recorded, learned from and displayed in a public area and to unit staff. The data we reviewed demonstrated consistent harm free care to patients.

Cleanliness, infection control and hygiene

- There were effective systems and processes in place to protect patients from the risk of acquiring hospital acquired infections.
- The Intensive Care National Audit and Research Centre (ICNARC) data reviewed demonstrated the unit had consistently low levels of MRSA (Methicillin-resistant Staphylococcus aureus) and C-Diff (Clostridium difficile) rates between January 2010 and April 2015.
- Infection control policies and procedures reflected national guidance.
- The unit appeared visibly clean and tidy. High dusting and curtain changes were undertaken regularly and bed spaces and ledges were dust free.
- Staff had access to an ample supply of PPE and were observed using it appropriately.
- The unit had side rooms available for the purpose of quarantining patients with infectious diseases or immunosuppressive illnesses.
- We observed staff complying with key infection control trust policies for example, hand hygiene, wearing personal protective equipment (PPE), appropriate use of isolation facilities, etc.)

- The visitors room had some children's toys stored in a box. Not all the toys were clean on close inspection. This was reported to the nurse in charge and action was taken to address the concern.

Environment and equipment

- The critical care environment was not meeting the national standards for critical care units. The space between beds was inadequate which created a risk to patients, for example in terms of infection control prevention. This also impacted on staff's ability to provide care and adhere to health and safety regulations when extra large medical devices or equipment was required to provide care.
- There were arrangements in place to deal with foreseeable emergencies.
- We noted that resuscitation equipment was checked twice a day, which coincided with shift changes. The checklists we viewed demonstrated that the two checks a day were not always completed. However the checklist revealed that at least one check was undertaken within a twenty four hour period, which is in line with trust policy. This meant that trust policy was being followed and equipment was regularly checked, but there were occasions where the second check was not always occurring.
- The paediatric resuscitation trolley was also checked during the inspection. The checklist demonstrated that the trolley was not always continuously checked. We noted that it was only checked on the 13/06/2015 and 26/06/015 for the month of July which meant that checks were not made as dictated by policy.
- On our previous inspection we were told there was a problem with the electricity supply to the CCU, which did not meet current national standards. The electrical supply had been reviewed and the need for extensive electrical work identified. We found the trust had taken the appropriate action to address the problems which had been resolved.
- The procurement team visited daily and the unit's specific needs are well understood. Staff told us about the positive relationships with the procurement team and the effective service delivery they provide.

Medicines

- There were systems in place to demonstrate that medicines were handled securely, and were securely stored and accounted for. Patients received their medications at the time they needed them and in a safe way.
- We reviewed a sample of medication charts (6 in total) during the inspection. We found the charts reflected national prescribing guidelines. Patients had their allergies and sensitivities noted and there was a record of regular pharmacist review and audit.
- When a medication was omitted, the reason was clearly documented. If a medication was omitted due to a clinical error, it was reported via the electronic reporting system and documented actions were taken to prevent recurrence.
- Medications were stored in locked cupboards in line with trust policy.
- Controlled Drugs (CD's) were stored, received and returned to pharmacy in line with trust policy. The CD register we saw demonstrated that daily stock checks were being completed and that drugs were being signed in and out by two staff members.
- Pharmacist support was regularly available and utilised on the unit.
- Staff had undertaken a competency based assessment before they were expected to administer medication on the unit.
- Twenty one out of twenty eight agency nurses employed by the unit had been assessed as 100% competent to administer IV (Intra venous) drugs.
- Medication charts were routinely audited to identify errors. These were reported and investigated as per trust policy and learning outcomes and action plans put in place to reduce recurrence.
- 'Drug buddies' system was introduced to reduce the rate of medication errors on the unit. Staff involved in drug errors identify their own causality and write guidance for colleagues to prevent the same issues happening in the future.

Records

- The medical records we viewed were found to be accurate, fit for purpose, held securely and remained confidential.

Critical care

- We identified a sample of records (6) to review during the inspection. Where it was possible, consent was obtained from the patients and or their relatives. We found the records to be in good condition and kept in chronological order.
- The records we viewed contained relevant risk assessments which were continuously reviewed as the patients conditions changed. For example we saw pressure area assessments and body mapping tools, nutrition and hydration assessments. We also noted that the trust expectation to record pressure scores graded 2 and above to be reported via the electronic reporting tool. However, the unit had taken the progressive step to ensure that all pressure lesions were recorded regardless of grade in an attempt to improve practice.
- We also saw that regular conversations between relatives and medical and nursing staff were recorded, and this meant that patients' loved ones were kept informed of progress and involved in the planning of care.
- Patients had their clinical observations monitored as frequently as their clinical condition indicated. These observations were documented on standardised intensive care documentation. High dependency patients also had their observations recorded on the electronic tool used throughout the hospital. This meant that there was a significant amount of clinical data available to ward staff upon the patient's discharge, which was useful to identify clinical trends.

Safeguarding

- There were systems and processes in place to protect the patients from the risk of abuse occurring.
- The safeguarding policy reflected national guidance and staff were provided with the necessary training to ensure they could meet patient's needs.
- The staff we talked with during the inspection were able to describe a safeguarding incident and could tell us how they would report it to the relevant authorities.
- 92% of critical care staff and 86% of the outreach team had received safeguarding training.

Mandatory training

- Staff were provided with the relevant training to ensure they met the care needs of the patients for whom they cared.
- Unit staff demonstrated a 90% compliance with mandatory training.
- 98% of critical care staff receive equality and diversity training, 97% moving and handling,. However, only 68% have received infection control training.
- 100% of the outreach staff were trained in equality and diversity, 86% had received training in moving and handling and safeguarding, but only 71% had received mandatory infection control training.
- The unit operated a competency-based structured training programme for all nurses and healthcare assistants.
- We were told that protected e-learning was in place for staff. However, staff told us told us they experienced significant problems accessing the e-learning during work hours and were encouraged to complete it at home. They also told us that accessing the system from home was also problematic.

Assessing and responding to patient risk

- We found patients had their care risk assessed, planned and delivered in a way which reduced the likelihood of them receiving unsafe or inappropriate care.
- The unit had two consultant led ward rounds daily.
- Patients in the unit had their conditions continuously monitored.
- Early warning scoring systems were in place for high dependency patients.
- When a patient was identified as deteriorating by nursing staff their concerns

were immediately escalated to a member of the medical team who provided a review and updated treatment plan.

- The medical records we viewed demonstrated that patients had timely responses whena review was requested, therefore the patient's needs were continuously monitored andidentified risks were managed appropriately.
- The critical care outreach team had access to an electronic observation and risk assessment tool which meant that they could use the data to identify patients who were at risk of deteriorating early, and thus could be provided with the required level of care needed to prevent deterioration.

Nursing staffing

- The unit had sufficient staff to meet the care needs of patients.

Critical care

- The unit was not continuously meeting the national standard for ensuring that a supernumerary changenurse was available on all shifts. We were told that the unit did its utmost to ensure the person in charge did not deliver patient care. However, the recent changes to agency contracts mean that the nurse in charge had to back fill some shift to ensure the unit could meet the needs of the patients and continue to deliver safe care. We noted that the unit performance in providing supernumerary cover has been substantially improved since our previous inspection.
- The department reported its actual nursing establishment as 56 Whole Time Equivalents (WTE) against an expected establishment of 69.5 WTE. The unit was supported by 3 admin staff and 6.2 band 7 outreach nurses.
- The unit used a staffing acuity tool. This tool measured the clinical needs of patients and staffing levels to ensure the correct number of staff were available to meet patients' needs.
- We attended a nursing handover during the inspection. We found it to be well structured and demonstrated good communication amongst the team. Nurses also had a detailed bedside handover once they were allocated their patient for the shift.
- The unit was almost compliant with the national recommendation of ensuring that 50% of the nurses on the unit had a recognised critical care qualification. The unit reported 48% of their nurses had achieved the qualification.
- If a vacancy arose, staff from the sister units would be asked to relocate to the William Harvey site.
- If this was not possible then the unit used agency staff to ensure that they had the recommended staffing and skill mix to care for patients. The agency staff used had been through a unit specific competency skills assessment and had achieved an intensive care nursing qualification. (including induction processes for these staff groups)
- The unit occasionally exceeded the national recommendation for agency staff that being over 20% of the work force.

Medical staffing

- We found suitable numbers of medical staff to meet patient's care needs and provide support for the nursing team.
- The unit had recently recruited four new CCU consultants and a new medical coverrota was to be implemented as of October 2015. This meant that there were three consultants with a recognised intensive care qualification on the unit and extra medical cover which would, in turn, aid the personal development of the other consultants who wished to achieve the qualification. This would also mean that the unit was taking steps to meet the national recommendations for CCU consultants with a recognised qualification.
- Consultants were available from 8am to 6pm, Monday to Friday and from 8am to

2pm at weekends. The consultant responsible for covering the unit ITU during the day is not expected to undertake other duties. Out of hours cover was provided by consultant anaesthetists which meant that they did not always have the desired critical care training. Consultant cover was available twenty four hours a day in line with the national recommendations.

- We attended a medical handover and ward round during the inspection and found both to be of sufficient quality. However, we noted the ward round could be improved upon in terms of the structure and length of time taken to complete.
- The department reported avoiding the use of locum staff to manage gaps in the department rota. Consultants in the department with the assistance of their anaesthetic colleagues opted to provide cover instead.
- The Consultant patient ratio did not exceed the national range identified as being between 1:8 – 1:15 and the ICU resident/Patient ratio should not exceed 1:8.
- Junior doctors told us that they felt supported by their consultant's colleagues, and described them as very approachable.

Major incident awareness and training

- There were systems in place to manage major incidents and appropriate business continuity plans which ensured that patients needs were met effectively, should such events occur.
- The trust had a major incident plan and policy in place. However, we did not see the appendices referred to in the policy as these had yet to be completed. We were assured that this would be addressed as a matter of urgency.

Critical care

- We noted that the policy had recently been reviewed and staff were able to tell us about what was expected of them should a major incident occur.

Are critical care services effective?

Good

We have judged the critical care service at the William Harvey to be effective.

The unit delivered evidenced based treatment and care, and was able to demonstrate consistent performance with national benchmarks. Policies and guidelines reflected NICE, (National Institute for Health and Care Excellence), Faculty of Intensive Care Medicine and the Royal Colleges; thus care was being delivered in-line with NCEPOD (National Confidential Enquiry into Patient Outcome and Death) and Royal College of Surgeons guidelines.

The unit participated in continuous data collection to monitor the service, provide data for national audit submissions, and benchmarking. There was an audit lead on the unit and we found the unit participated in audit activity that had resulted in national publications. However, there was no formal audit timetable in place and not all junior doctors undertook audit as part of their critical care placement. This meant that the unit and the juniors were missing a valuable opportunity to impact on the quality of care and to develop professionally.

We found appropriate systems in place to ensure that patients had their pain needs assessed and addressed continuously. Patients had their nutritional needs continuously risk assessed and evaluated with a multidisciplinary approach to the care delivered. National guidance was being followed to ensure that patients were not left for long periods of time without adequate nutrition.

The unit had a multidisciplinary patient centred approach to the care delivered. Daily ward rounds by a multidisciplinary team have been associated with lower mortality in critical care. There was a seven day approach to the care delivered and there was adequate access to diagnostics, medical reviews and support services out of hours.

We found a very supportive environment for staff to learn and develop their skills. There was a strong commitment from the practice educator, university links and unit mentors to facilitate personal learning and career development. Staff had the opportunity, and were encouraged and supported to acquire new skills and share best practice.

Staff who delivered care and treatment had a central role in monitoring and assessing quality, and the development and review of policies, procedures and practices.

There was a proactive approach to ensuring that staff have the right skills and experience to provide care and treatment.

Evidence-based care and treatment

- We found systems in place which meant that the service took account of published research and national guidance. The unit also used the findings from local and national audits to ensure that action was taken to protect patients from the risk associated with unsafe care and treatment.
- Policies and guidelines reflected NICE, Faculty of Intensive Care Medicine and the Royal Colleges; care was being delivered in-line with NCEPOD (National Confidential Enquiry into Patient Outcome and Death) and Royal College of Surgeons guidelines.
- We found the unit was implementing recommendations from NICE clinical guideline 83 on critical care follow-up and rehabilitation by developing a dynamic robust rehabilitation service for patients.
- We found unit staff adhered to local policies and procedures as well as national ones, and that their performance in the light of these was included in the units audit cycle.
- The unit had one person employed for the sole purpose of the collection and collation of data for the unit. This meant that the unit was able to provide data in a consistent and timely manner to the trust and ICNARC. We found the unit had a proactive approach to audit in the unit and used the results to continuously improve the standard of care delivered.
- We noted the unit undertook regular audit activity and had a consultant audit lead. The audit activity had resulted in two national publications; however, there was no formal audit timetable in place. Not all the junior doctors were undertaking audits during their critical care placements. This meant that the unit and the juniors were missing a valuable opportunity to impact on the quality of care and to develop professionally.

Critical care

Pain relief

- There were systems in place which ensured that patients had their pain needs assessed and addressed in an appropriate way.
- The unit used an appropriate pain scoring tool to measure and identify patients pain levels.
- We saw a wide range of methods used to administering analgesia on the unit. This ranged from oral, intravenous, PCA (Patient Controlled Analgesia), epidural and spinal blocks.
- Patients had routine pain relief prescribed on admission to the unit which meant that if a patient required pain relief it could be administered without delay.
- Where PCA and epidural analgesia was being used the appropriate safety protocols were in place. For example, anti-emetic medication (effective against nausea and vomiting), reversal agent and fluids were also prescribed for use in the unlikely event of an emergency. Patients with these methods of pain relief also had the appropriate safety observations carried out regularly, for example, epidural block levels.
- The nursing documentation we reviewed demonstrated that patients had their pain needs regularly assessed and acted upon.
- The patients we talked with told us that they received adequate pain relief. The relatives we spoke to also confirmed that their loved ones pain needs were met.

Nutrition and hydration

- There were effective systems in place to ensure that the risk of poor nutrition or dehydration was identified and acted upon admission to the unit.
- We observed all the patients on the unit receiving suitable nutrition for their individual conditions. This ranged from normal diet for HDU (High Dependency Unit) patients, to NG (Naso Gastric - a tube that accesses the stomach via the nose) and TPN (Total parenteral nutrition- which is a method of feeding that bypasses the gastrointestinal tract).
- Patients received nutrition in a timely manner and within the timeframe set out in best practice guidance outlined by the Intensive Care Society and NICE CG32.
- All patients had a MUST (Malnutrition Universal Screening Tool) risk assessmentin place and had been weighed on admission to the unit. Their weight was continuously monitored and documented.
- Nursing documentation demonstrated that patients had their fluid intake and output monitored continuously and the actions taken if an intervention was necessary.
- All patients were reviewed by a dietitian and speech and language therapists if necessary.
- The trust had a nutrition policy in place, however, we found that it did not reflect best practice of X-Ray checking to ensure the correct position of the NG tube before feeding. We were aware that a standard cross-site approach to checking did not exist. For example, one hospital had a serious incident where the position of the NG was checked according to the trust policy, however the tube was not in the patient's stomach. Feeding was commenced and caused avoidable harm to that patient.
- The hospital site where this happened took the decision to ensure that all patients had the position of their NG tube x-rayed before use to guarantee its position. We are very concerned about the lack of consistency across the sites especially as the CQC were aware of an incident involving the incorrect position of an NG tube which resulted in serious harm to a patient which occurred on the 17/07/2015. This could suggest that cross site learning from these incidents is not as robust as it should be.

Patient outcomes

- We found that Information about patient outcomes and the risks to health, welfare and safety, errors and near misses was gathered, analysed to identify the risk of inappropriate or unsafe care.
- The unit was not identified as a CQC outlier. A CQC outlier can be defined as a programme that looks at patterns of death rates within NHS Trusts.
- ICNARC data demonstrated positive patient outcomes for unit patients. For example unit mortality for admissions with severe sepsis, pneumonia, elective and emergency surgical admissions and ventilated patients was in line with units of a similar size and the England average.
- Data reviewed for unplanned readmission within 48 hours was reported as being less than one percent.

Competent staff

- CCU staff were properly supported to provide care and treatment to patients. They were properly trained, supervised and appraised and encouraged to gain additional qualifications.

Critical care

- The National Competency Framework for critical care nurses was commenced at the end of a four week induction for new staff. The unit provides a formal one-year preceptorship programme. This supports staff from novice to expert, and staff were expected to build a portfolio of evidence to illustrate their learning. There was also the option to take an academically accredited preceptorship module.
- All nursing staff have attended an 'acutely unwell patient' training.
- A clinical education strategy was in place to focusing on equipment training.
- We saw evidence that the unit facilitated bi-annual supervision and annual appraisals for staff. The staff we spoke to also confirmed that this was the case.
- All nursing staff were subject to nursing registration checks and the unit was in preparation for the new Nursing and Midwifery Council (NMC) nursing revalidation processes.
- Evidence demonstrated that revalidation for medical staff was carried out in line with Royal College recommendations.
- 48% of the nursing staff held a critical care qualification. The national recommendation for units is 50%. However, the unit achieved the national standard as only agency staff who held this qualification were employed. Staff without the critical care course were receiving the appropriate support and encouragement to seek the qualification.
- We found evidence that agency nurses were provided with induction and area orientation before they started work. This included daily care plan completion (risk assessments, waterlow score, changing of IV lines) and VitalPac, tour of the unit, emergency equipment storage etc. Agency nurses also have the date of their critical care course, and a refresher provided if necessary.
- Medical trainees on the William Harvey site had access to a dedicated and structured critical care teaching programme.
- The unit had guidelines and an induction package in place for newly appointed consultants.

Multidisciplinary working

- There was evidence in the medical records we viewed, and the conversations we had with staff and relatives, that the unit took a multidisciplinary approach to the care. During the inspection we spoke to a range of staff who had a professional input into the care delivered.
- Entries in the medical records demonstrated a wide range of professional input into care. For example physio, dietician, microbiologist, speech and language therapists, pharmacists, surgical and medical team input.
- All patients discharged from the unit were followed up by the outreach team and the physiotherapists involved in the rehabilitation service.
- The unit had a critical care outreach team who worked on the sites twenty four hours a day. Their role was to monitor andthe availability of CC outreach team.

Seven-day services

- The unit provided consultant-led care seven days a week. Consultants worked on the unit between eight a.m. and two p.m. at weekends and out of hours cover was provided by consultant anaesthetists.
- An on call physiotherapy service was also provided at the weekends which meant that patients continued to receive the same standard of care at weekends.
- There was also an on call pharmacist available to provide support to the unit out of hours.
- We found suitable access to imaging, and pathology, but we noted that there was no OT (Occupational Therapy) service provision.

Access to information

- We found the unit provided information which supported patients and their relatives to make decisions about their care and treatment and the services available to them.
- Information for relatives was displayed in the waiting rooms and corridors of the unit. Relatives we spoke to told us they felt they could approach staff to ask for additional information if required.
- We also found appropriate access to the latest information for staff on the unit.

Consent and Mental Capacity Act

- There were systems in place to gain and review consent from those who used the service. Patients could be confident that their human rights were respected and taken into consideration.
- We found evidence that patients had their mental capacity assessed and the assessments acted upon if necessary.

Critical care

- Staff were aware of their role to determine capacity and the processes required to escalate any concerns identified.
- We reviewed DNACPR (Do Not Attempt Cardio-pulmonary Resuscitation) documentation and found that it reflected national guidance. There were also detailed entries in patient's notes to suggest that conversations regarding Do Not Resuscitate orders involved patient's families and loved ones. There was also evidence that these orders were reviewed regularly with patient's conditions.
- The staff we talked with were less confident in their knowledge of DoLs (Deprivation of Liberty Safeguards). However, they were able to provide evidence that risk assessments were carried out when patients were forced to wear mittens (a medical restraint).

Are critical care services caring?

Good

We have rated care in the critical care unit at William Harvey hospital to be caring.

We spoke to a total of nine relatives during the inspection and reviewed service feedback for a period of 12 months in order to evaluate the service provided on the unit. Families were actively encouraged to give feedback to the service and evidence we reviewed demonstrated positive responses in all areas. The verbalfeedback from people who use the service, and those who are close to them was entirely positive. Some of the comments received were "I trust the staff in this unit to look after my daughter, and that's not something I get to feel all the time in other places" and "the communication here is great".

We observed staff treat their patients and their loves ones with dignity respect, compassion and empathy. Where possible, we saw staff interact with and involve patients and their relatives when making decisions about their care. This meant that patients and their loved ones felt supported and involved in the care being delivered. Relatives told us they felt the care delivered was in line with patients' medical needs and personal wishes.

There was ample written material available in the relatives' room and unit entrance which provided information about the hospital, and the critical care unit. For example, there was a resource booklet for relatives that described the unit, its functionality and routines as well as resources and support available to relatives during their stay. It also provided information about staff designation in terms of uniform colour and role performed and a picture board of staff was easily accessible, close to the relatives' room. There was other useful information about how to contact the unit, visiting times and how to access spiritual support. A selection of feedback forms and a post box was available for relatives to make comments or raise concerns confidentially and anonymously if preferred, in each waiting room.

We observed staff respond compassionately to patients and their loved ones' discomfort and emotional distress in a timely and appropriate way. The relatives we spoke to praised the staff not just for their "dedication"to patients but also for making time to ensure families were kept well informed.

The staff we observed and service feedback we reviewed demonstrated that

staff built positive and considerate relationships with patients loved ones. Staff took time to interact and involve loved ones and their communication was seen as effective and tactful,which encouraged positive relationships to form.

Relatives and loved ones felt very supported by the unit staff to cope emotionally. Some of the comments we received included "The staff are wonderful" and "they always make sure I'm ok and that I know what's happening".

Staff ensured that patient confidentiality was upheld and respected at all times.

Compassionate care

- We observed the staff on the unit being very kind and caring toward their patients. We witnessed nurses touching and talking to unconscious patients. This has been recognised as a valuable form of communication as it provides reassurance to unconscious patients, and therefore reduces psychological anxiety and critical care psychosis.
- We also observed nurses communicating with relatives and loved ones. The approach and communication style used was professional and demonstrated empathy and understanding.

- We found personal care was delivered in dignified, respectful and individualised way which promoted patient's human rights and respected their individual preferences.
- A total of seven relatives were spoken to during the inspection on this unit and the feedback inspectors received was entirely positive. This included feedback about the care their loved ones had received, staff behaviour and communications style, and how involved they felt in the care being delivered and the sudden changes to a patient's condition. An example of comments received included “We really appreciate their honesty, we know it's not easy”, “the staff are just wonderful” and “they do an amazing job”.
- The unit did not use the standard Friends and Family test but did operate other means of obtaining feedback from relatives. The survey results had a high response rate and indicated very high levels of satisfaction regarding the care and treatment their loved ones had received on the unit.

Understanding and involvement of patients and those close to them

- Patients and their relatives were helped by staff to understand the care and treatment options available to them. Those acting on behalf of patients were encouraged to share and express their views appropriately when making decisions about care their loved one was receiving.
- From the medical records we viewed and the ward round we attended we saw that the opinions of patients, and at times those close to them, were involved in the decision about the care and treatment that was to be provided.
- The relatives we spoke to told us they received adequate information and updates from the nursing and medical teams. This was evidenced from the conversations we had with relatives during the inspection, as well as reviewing the collated feedback in the medical records. People told us that they were continuously updated and kept informed of any changes to their loved ones conditions.
- The relatives we spoke with told us that they felt able to contact the unit at any time, night or day, to get regular updates on their loved ones’ progress. This meant that relatives were empowered to contact the unit to ensure they had the most up to date information at all times.
- Critical care diaries were in use on the unit, however their use was sporadic and not standardised. This meant that the unit was missing an opportunity for patients to reflect on their time on the unit and reduce the effects of stress, post-traumatic stress syndrome and other emotional conditions that affect quality oflife after critical illness and mechanical ventilation.

Emotional support

- Emotional support was mainly provided by the nursing staff on the unit. The Trust had specialist nurses who provided specialist knowledge and support to families for example, cancer, bowel and learning difficulties specialist nurses. There was a chaplaincy service available to provide emotional and spiritual support for patients and their loved ones.
- Support was also provided by the outreach team who had continuous contact with patients and their loved ones before and after discharge from the unit. Staff told us about the importance of ensuring that they not only supported their patients, but also their families. The relatives we talked with told us that their emotional needs were being met.
- ·Patients had their individual risk of anxiety and depression assessed and acted upon. Support included reassurance from nursing and medical staff, and referrals to the appropriate professional. We were told that there was no formal psychological or counselling services provided. However, if necessary, a referral could be made to external providers.
- The unit operated a very robust and effective bereavement service for relatives. This included a specific bereavement pack that was provided for relatives and includes information on health and wellbeing of the relatives, support groups, bereavement register forms and a list of suggested organisations which need to be notified of a death. There is also a notification of death form which needs to be filled out once and used to inform a range of organisations. This meant that relatives were spared the emotional upset of repeated form filling.
- One month after a death a member of staff contacts the next of kin to carry out a welfare check and provide additional support and information, if required. This approach to bereavement support has been rolled out across the three critical care units. Each unit has a bereavement lead and meets with the leads for the other units regularly to ensure continuity and a

standardised approach. Bereaved relatives were encouraged to give feedback about the quality of the support they received from the units. The data we reviewed demonstrated very high levels of satisfaction and immense gratitude to the staff who provide the service.

Are critical care services responsive?

Good

We have judged the service delivered in the critical care unit at William Harvey to be responsive.

Access and flow to the unit was identified as a concern. Data reviewed demonstrated that whilst the unit was making the admission referral targets, it was failing to avoid out of hours and delayed discharges.

The service was found to be providing the local population with care which was responsive to their needs.

Staff always acted in patients' best interest and delivered an individualised service. They took into account patient's personal preferences and human rights when delivering care. This meant that the service promoted person-centred care, promote good health, wellbeing and independence.

The service promoted equality, and met the needs of people in vulnerable circumstances. We found a robust rehabilitation programme which focused on supporting people to regain independent living and of preventing unnecessary re-admissions.

The conversations we had with patients, relatives and staff indicated that patients and their loved ones were involved in decision-making about their care and choices available to them. They also told us they had their spiritual and cultural needs met whilst on the unit. The medical records we viewed also demonstrated this level of involvement. There was an ample supply of information about the unit and condition specific resources for relatives in the waiting rooms. This included the facilities available to relatives whilst in the trust.

The unit received very low levels of complaints and there was an effective and robust complaints process. There was documentary evidence that showed the service continuously reviews and acted on feedback and complaints about the quality of care. This information was used to improve the service delivered.

Service planning and delivery to meet the needs of local people

- The service had responded to the needs of its local population by providing two extra unfunded beds to improve capacity on this site.

Meeting people's individual needs

- Patients had their individual needs and preferences met whilst on the unit.
- Staff always act in the person's best interests and comply with the law if they need to restrain someone during their care.
- Unit staff were inducted on the dementia care pathway and pan-trust dementia group.
- The unit used alternative methods of communication: for example by using pictures or writing and providing easy-wipe boards for patients.
- Translation services were available trust wide, as was a selection of patient information in a range of languages.
- The trust had a learning difficulties team and lead nurse who provided support for patients, relatives and staff.
- There was a trust policy in place which encouraged communication with community services if patients with learning difficulties had repeated admissions.
- Where appropriate, we saw staff ask patients for their consent before carrying out care and providing relevant information about the care and treatment they were providing to patients.
- Nursing documentation reviewed demonstrated that patients had their individual preferences recorded to ensure individualised care, and care-continuity, could be achieved.
- Patients with complex needs who were admitted to the unit without a 'This is me' document (hospital passport which contains individualised specific information) had one completed within 24 hours with the assistance of their loved ones. This was to ensure that staff could meet people's needs in a way that reflected and respected those needs and preferences.

Access and flow

- There were problems with access and flow in the critical care unit. Whilst the unit and its senior management

have worked tirelessly to provide extra beds in an attempt to address the capacity issues, the unit reported capacity to be between 85% and 100% from November 2014 to February 2015. National recommendations for unit occupancy is currently set at 85% which meant that the unit was continuously exceeding this target. The primary reason for this was the capacity in the unit itself, and capacity on ward areas which caused long discharge delays.

- Problems with capacity in the unit resulted in occasional mixed-sex breaches as a result of delays in transferring or discharging patients. Where this occurred, an incident was recorded and senior staff looked at the cause of each instance to identify areas for learning in future practice.
- Admission to the unit was by referral to the consultants only. Once the referral was received and reviewed, a consultant made the decision to either admit or refuse the admission.
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- The average length of stay reported for 62% of patients was recorded as up to one full day. 20% of patients had an average length of stay of 1 day and 18% of had a stay exceeding two to seven days.
- Despite concerns with delayed discharges data suggested that there were minimal out of hours discharges on the unit, with data from 2013 to 2015 indicating that such discharges were always at or below the national average. There was a perception amongst staff that there was a direct correlation between the availability of ward beds and the bed managers individual skills and clinical insight.
- Data presented to the CQC showed a reduction in the numbers of transfers out. In 2013 there were a total of 26. 2014 a total of 21 and for Jan to June 2015 the number had reduced to four.
- Delayed discharges were at or above the national average between 2010 and 2015 in all but three months. From April 2015 - July 2015, 70% of discharges were delayed, with 58% delayed for between four and 24 hours. Discharges that were over 24 hours had significantly reduced in the first quarter of 2015, with 15% of discharges delayed up to a maximum of three days. This was noted by staff on the unit's risk register, which indicated a consistent approach to using the escalation policy and root cause analysis process to improve access and flow movements. There was no indication that patient safety had been compromised as a result of problems with flow.
- The unit continuously collected data on the amount of elective surgery cases which were cancelled due to lack of critical care beds. The data demonstrated that these numbers were high, however, when looked at closely the data and the reasons given for the cancellations revealed that it was predominately because the bed was not needed. This may suggest concern with the quality of pre-assessment procedures. In the first quarter of 2015 there had been only four cancellations, indicating an improvement in this area.

Learning from complaints and concerns

- We saw documentary evidence that complaints data was routinely reviewed and staff meeting minutes demonstrated that complaints were routinely discussed. This meant that the service monitored complaints to improve service quality and to aid learning in the department. Staff meeting minutes demonstrated that complaints were discussed with unit staff.
- There was an appropriate trust-complaint policy in place which was being followed by the unit.
- We also found evidence of an effective system in place to deal with comments and complaints. The unit provided, when necessary, support to those who wished to raise a concern or complaint.
- At trust level the Patient Advice and Liaison Service (PALS) provided assistance to patients and their families wishing to raise a concern or complaint.
- We reviewed complaints data for the last twelve months and found the service received a very low level of complaints. At the time of the inspection there were no outstanding complaints. We saw documentary evidence that the unit had received two complaints for 2015 and despite one not being specifically relating to the unit, it was subject to a full investigation. There was evidence that the affected relatives were invited to a face-to-face meeting with hospital staff to discuss their concerns. This demonstrated effective, responsive and complainant-centred approach to complaint handling.
- The nine relatives we spoke with told us they had no concerns or complaints with the service provided on the unit. They went on to tell us that they were aware of the complaints process and felt, but insisted, that they had

'nothing to complaint about'. They told us they knew how to raise a concern or complaint should the need arise. Relatives we spoke to felt confident that their complaints or concerns would be listened to and acted upon effectively and in a timely manner.

Are critical care services well-led?

Good

We have judged the critical care unit as well-led. The unit was found to have a realistic vision and strategy which reflected the needs of the service. The staff who worked on the unit expressed support for the vision, and felt that their opinions were taken into account in the creation of the strategy. The vision not only took the needs of the local population into account but also reflected on areas impacting on staff and the latest national guidance. However, due to the recent changes to the leadership in the organisation, and the current financial position of the trust, there was little reassurance that the local vision and strategy was part of the wider trust agenda. The lack of clarification meant that improvements plan were stagnant and left staff feeling in limbo.

The unit evidenced appropriate and effective quality drivers and measurement tools to ensure that it was providing a good service in line with national guidance and other units nationally. We found operational governance and risk management arrangement were in place to support the unit to deliver high quality care. We also found evidence that the unit had systems in place to promote a healthy, open and candid culture in the department.

Patient and relatives experience was continuously sought, reported and reviewed, and used to improve the service delivered. Staff placed a high value on public feedback and engagement and people felt their concerns were listened to and acted upon.

Staff felt respected, valued and essential to the service delivered on the unit. Staff demonstrated an open and candid approach to their practice. Staff had their individual performance challenged, but were supported to develop by their team leaders.

From the documentary evidence we reviewed and the conversations we had with staff demonstrated effective leadership and communication. Managers were described as visible, accessible and approachable.

The organisation supported innovation and encouraged staff of all grades to get involved in and deliver service improvement. Staff regularly took the time to review performance and take action to improve, by using reflective practice, supervision and discussions with team leaders.

Vision and strategy for this service

- The unit had a realistic vision and strategy which reflected the needs of the service as well as an enthusiastic staff who felt empowered to drive improvements which impacted on service delivery. The proposed plan required significant financial investment to be delivered. However, due to the financial implications and the recent changes to leadership at board level, there was no assurance that the unit strategy fitted into the trust plan. We found the lack of clarity and direction from the trust board had left staff in a position of limbo and uncertainty.

Governance, risk management and quality measurement

- Meeting minutes we viewed and the conversations we had with staff demonstrated that the unit operated effective Governance, Risk and Quality measurement processes. For example, the service noted that medication incidents were an area of concern for the unit. This was discussed through the governance group and a trust wide medicines group was formed. Actions taken included the implementation of a buddy system and a random audit process was introduced.
- Minutes we reviewed demonstrated that risks identified and reported were related to the multidisciplinary critical care steering group and the surgical division governance board.
- Staff were aware of, and felt involved with and expressed confidence in the various processes for safety and quality, service improvement and the management of risk on the unit.
- We found that the service had effective and appropriate systems in place to mitigate risks in infection control, staffing control, staffing, patient outcomes and capacity/ flow.

- We saw records to demonstrate that appropriate risk assessments were being carried out in critical care. For example, up to date risk assessments for the two extra beds and their safe staffing levels.
- The service demonstrated it had effective processes in place for carrying out clinical audits and actions were taken when required to resolve concerns.
- The unit had an appropriate risk register in place (reflecting risks in the service) and clear lines of responsibility. The top risks to the service were identified as delayed discharges, staffing recruitment and retention and the environment.

Leadership of service

- We found evidence of a strong and inclusive leadership style in the unit.
- There was a designated clinical lead consultant, an identified matron as well as a

Consultant nurse. Consultants and senior nurse management engaged with their equivalents at the other sites to aid communication, learning and standardisation. However, we found engagement between the lower bands (3 - 6) could be significantly improved.

- It was clear from our conversations, and the documentary evidence we reviewed, that staff had confidence in the leadership.
- Staff told us they felt the local leadership engaged with them in a meaningful way and felt that their opinion really mattered.
- Staff reported feeling very supported by their teams and immediate line managers. They also told us they felt valued and supported.
- There were systems in place for staff to raise concerns either anonymously or directly and confidentially to team leaders.

Culture within the service

- Our last inspection identified some concerns regarding the culture in the unit. This inspection recognised that steps had been taken to improve the culture.
- The measures taken by the leadership of the unit to address the concerns identified by the CQC, were outstanding initiatives. The improvements were driven and directed by the staff which gave them control over the process of reflection, resolution and improvement. This approach was reflected upon as 'positive' and 'empowering' by staff. For example, staff questionnaires were introduced before staff meetings. Staff were encouraged to leave feedback on their wellbeing, meeting satisfaction, unit communication and improvements to culture and when necessary, staff diaries were introduced as a reflective development aid. We saw documentary evidence of culture concerns that were effectively managed.
- Staff told us they initially did not recognise the areas of concern regarding culture as identified in the previous report. However, they felt that in reflection, there were several changes required to improve communication and make staff engagement more meaningful.
- Staff felt their job made a difference, they were proud of the standard of care they delivered and felt they would be happy for their loved ones to receive treatment in the unit. All of this resulted in a happy staff group which displayed good morale.
- Staff told us that the culture was much improved. They also told us how proud they felt of their ability to work cohesively as a productive team.
- The staff we talked with were found to be very open and transparent in their approach to the inspection process, which was indicative of a healthy culture in the unit.

Public and staff engagement

- The unit encouraged on-going staff engagement. We viewed the continuous staff feedback gathered at meetings which was collated and had documented action and progress records. The feedback included information about staff well-being as well as their opinions on the team and leadership dynamics and the operational functionality of the unit.
- The staff we talked to expressed feeling involved and engaged with the leadership.
- Relatives told us they felt involved in the care delivered to their loved ones.

Innovation, improvement and sustainability

- 'Drug buddies' system: Evidence of efficacy. for example a nurse with prior drug errors is now a drug champion helping others to improve their practice.
- 'Delivering Performance Policy' – ensures appropriately trained/competent staff are supported with their workload.
- Bereavement service provided by unit staff.
- 'Challenge 500' – advertised to staff to get involved in fundraising and improve awareness of dementia.

Maternity and gynaecology

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

Information about the service

The East Kent University Hospitals NHS Foundation Trust provides all services relating to pregnancy and women's health. As part of this inspection we reviewed the obstetrics and gynaecology services at the William Harvey Hospital, the Kent and Canterbury Hospital and the Buckland Hospital. We also reviewed the obstetric care to women in the community. The Trust also provides maternity and gynaecology services from the Queen Elizabeth the Queen Mother hospital which is subject to a separate report.

The William Harvey Hospital provides antenatal and gynaecology clinics; a fetal medicine unit; a maternity day care unit; Folkestone Ward a 28 bedded ante and post natal inpatient ward; a consultant led labour ward with three induction beds, eight labour rooms and a birthing pool; There is one obstetric theatre; the Singleton Unit, a midwife-led unit with six rooms and two birthing pools. Kennington ward has 15 inpatient beds for general gynaecology, a nurse led pre-assessment clinic for all elective admissions and a nurse led early pregnancy assessment unit.

Community midwives provide ante and post natal care for women; either at their home or from community based clinics such as GP surgeries and children's centres. The community midwives also offer a home birth service.

Last year the trust delivered 7,032 babies including home births. Of these over 4,000 were delivered at the William Harvey Hospital. 735 of these were in the midwife led birthing unit. About 820 women a month attend antenatal clinics at the hospital. The gynaecology service provided over 900 outpatient sessions a month. Gynaecological surgery is carried out both in the dedicated obstetric theatre and the hospital's main theatres.

We visited all inpatient areas of the maternity and gynaecology services as well as outpatient areas. We spoke with 14 women and their relatives and reviewed 11 sets of patient records as well as other documentation. We observed care and treatment and spoke with over 30 staff who were working in a variety of roles including the division director, acting head of midwifery, matrons, ward managers, midwives and their assistants, specialist midwives, community midwives, student midwives, labour ward coordinator, ward clerks and the community liaison officers. We held focus groups for staff and received information from members of the public who contacted us to tell us about their experiences both prior and during the inspection. We also reviewed the trust's performance data.

At our last inspection of the maternity and gynaecology services offered at the William Harvey Hospital we found that although mothers received care that was delivered with compassion, dignity and empathy, there was not enough staff to provide a safe service to women during their pregnancy. The midwife to birth ratio was over 1:33. The accepted ratio is 1:28 midwives to births. There had been frequent closures of the midwife-led Singleton unit which had reduced choice for women and meant that some women were transferred to other units for non-clinical reasons. We found that leadership vacancies and interim arrangements had continued for significant periods. Clinical guidance and policies used by staff were out of date.

Maternity and gynaecology

Summary of findings

We found the maternity and gynaecology services at the William Harvey Hospital, required improvement, because the majority of issues identified in the previous report had not been addressed.

Since the last inspection the midwifery service had been through a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. The Trust had identified a culture of bullying and harassment. The lack of leadership, the culture of bullying and lack of strategic direction was felt throughout the midwifery team and had resulted in a lack of focus and direction for the obstetric service at the William Harvey Hospital for several months. These issues had not affected the gynaecology services which had benefited from stable leadership for some time.

Since April 2015 progress had been made with stabilising the midwifery service. A number of interim, acting and substantive posts had been filled. The Trust was now engaging with staff and had launched of a staff charter to encourage positive work place behaviour. The majority of staff were encouraged by these initiatives and told us the Trust was now a good place to work and getting better. Because of the leadership issues in the midwifery services in the past year there had been little focus on auditing, innovation and developing practice. However now the senior management team was becoming more settled, managers were starting to involving staff in developing the service for the future.

There remained a problem with understaffing across women's health services. There had been some progress made with the Trust now actively recruiting to the vacancies, agency and bank staff now being used and an improved midwife to patient birth ratio. However it was still routine practice for staff to go without meal breaks or work over the end of their shift in order to ensure the ward was covered, to catch up on documentation and to keep women safe. Women sometimes experienced delay in obtaining pain medication while waiting for a second nurse to check medications and qualified staff spent time when they could be attending and supporting patients undertaking routine administrative work especially at weekends.

Staffing in the gynaecology ward remained an issue because services were stretched with medical outliers and the use of a four bedded bay that was not funded for extra staff.

At the previous inspection we found there was a lack of capacity with the maternity units across the Trust closing on many occasions. There had been no change in this situation with over 88 closures or diverts happening in the past year. This reduced the choice available and meant that women in labour had to travel more than 30 miles to the next available hospital

There remained issues with the general environment and lack of equipment across the obstetric department. There was a shortage of basic medical equipment from medical devices such as resuscitation equipment to broken printers and photocopiers. At the William Harvey Hospital we found the temperature on Folkestone ward and in the labour ward was uncomfortably hot. The air-conditioning units had not worked for many months and both patients and staff were suffering in the heat. There was a lack of en-suite facilities for women in labour, poor bereavement facilities, only one obstetric operating theatre for both emergency and elective procedures, little storage space available and the midwife led unit could not be kept secure because of a fire exit from the neighbouring ward. Although the general environment across women's services were visibly clean, the basic design and worn furnishings presented problems with regard to infection control.

Throughout the problems with obstetric leadership and staff unrest during the year we noted that staff had continued to provide women with positive pregnancy and birth experiences. Women told us that they were usually involved in decisions about their care, and were kept up to date with their progress. Emotional support was provided by staff in their interactions with patients, together with support from specialist lead midwives. The majority of feedback received across women's health services was positive and the kind and caring attitude of the staff praised.

Both the midwife led unit and the consultant led unit had rooms with pool facilities and a variety of couches for women in labour. These were well situated and well

maintained to offer women a real choice in how they wished to give birth. There was effective multidisciplinary working both within the hospital and with outside agencies.

We found there was under reporting across the maternity service. Although staff were good at recording any clinical incident, non-clinical events were not being recorded. The Trust was aware of the issue of under reporting and had strengthened the governance system and improved training and development in reporting and managing incidents and complaints. Staff in the gynaecology services reported incidents appropriately and demonstrated a good incident reporting culture.

We saw that a thorough review of all relevant policies and procedures had taken place to ensure they met with current best practice. There were mechanisms in place to enable staff to learn from any accident, incident or complaint. We saw that clinical governance arrangements were improving with the change in culture. Staff were now more confident at raising concerns with their managers and whistleblowing when things were not right. Staff demonstrated a good understanding of infection control procedures, with robust monitoring of their effectiveness. We found that staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable women and their babies.

The majority of the obstetrics and gynaecology nursing records and medical notes we reviewed were well completed. However there was a risk that babies were could miss the newborn screening test as NHS numbers were allocated manually with insufficient printers in place. The hospital had systems in place to identify when patients who were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patients' risk.a

Are maternity and gynaecology services safe?

Requires improvement

We found that the safety aspects of the maternity and gynaecology services at the William Harvey Hospital required improvement.

We found that patients were not always protected from avoidable harm because there was under reporting of incidents on the obstetric wards. Although the Trust was proactively working to address the issues staff were still not always reporting non-clinical incidents. This was not the same for the gynaecology wards who demonstrated a good reporting culture. At this inspection we found that although the midwife birth ratio had improved, there continued to be a number of vacancies across the maternity and gynaecology departments. The Trust's inability to safely staff the acute sites at times of high activity or unanticipated staffing issues meant that there were occasions when understaffing impacted on the care patients received. Understaffing was an area not often reported through the Trust's reporting systems.

The environment was not always a safe place to care for women and their babies. There was one obstetric operating theatre for both emergency and elective procedures, there was little storage space available and the midwife led unit could not be kept secure because of a fire exit from the neighbouring ward. Although the general environment across the hospital sites was visibly clean the basic design and worn furnishings presented problems with regard to infection control. There was a shortage of basic medical equipment from medical devices such as fetal monitoring equipment, infant resuscitaires and CTG devices to broken printers, photocopiers and electric fans. There was not always enough emergency resuscitation equipment available, appropriately checked and ready for use in suitable locations throughout women's health services.

Although we note an improvement in medicine management there were still some practices which did not meet current best practice or comply with national guidelines such as out of date guidelines, unlocked drug fridge and cupboards and expired medication.

Maternity and gynaecology

The majority of the nursing and medical notes we reviewed for both obstetrics and gynaecology were well completed. However there was a risk that babies could miss the new born screening test as NHS numbers were allocated manually.

We found that staff attendance at mandatory training was good across women's health services and staff were knowledgeable in how to safeguard and protect vulnerable women and their babies.

The hospital had systems in place to identify when patients who were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patient's risk.

There were robust systems and processes in place to ensure that a high standard of infection prevention and control was maintained throughout the theatre and both obstetrics and gynaecology wards.

Incidents

- It is mandatory for NHS trusts to monitor and report all patient safety incidents. At the William Harvey Hospital all incidents were reported through the trusts electronic reporting system. There was an incident reporting policy and procedure in place that was readily available to all staff on the Trust's intranet.
- The trust had reported no maternity or gynaecological 'Never Events' over the past year. Never Events are serious, largely preventable safety incidents such as retention of a foreign object following surgery or wrong route administration of medication.
- The maternity dashboard documented 28 serious incidents reported in the past year that met the criteria for reporting through StEIS, the national reporting database.
- These mainly concerned unexpected admission to the Neonatal Intensive Care Unit and unexpected Neonatal death. Other incidents included an intra-partum death and sub optimal care of a deteriorating patient and baby.
- We looked at the Trust's investigation into the six most recent maternity incidents. We saw that a root cause analysis had taken place and there was a system in place to undertake an investigation of each of the incidents including assessing if there had been any shortfall in care, treatment or service delivery. The process included establishing if recurrence could be eliminated and identify the lessons learnt. We saw that staff, patients and relatives were supported and informed of the outcome. Action plans were put in place which included sharing learning and any changes in practice.
- There had been 23 reported incidents relating to the Kennington Ward (Gynaecology) over the past six months. These were all classified as 'No Harm' or 'Low harm' incidents. There were no patterns or trends identified in these incidents. We saw that appropriate action had been taken to investigate and resolve each of these issues. We noted that staff on the gynaecology wards reported all incidents appropriately including non – clinical issues such as near miss incidents, inappropriate patient transfer, faulty equipment, catering and security issues. This demonstrated a good reporting culture on the gynaecology wards.
- Staff told us that the governance around incident reporting had improved over the past year. They told us that they now usually received feedback from any reported incident and that any learning was disseminated through team meetings, ward meetings, email communications and the clinical governance newsletter 'Risky Business'.
- We saw copies of the 'Risky Business' newsletter on staff notice boards giving details of learning from recent incidents. Staff spoke positively about 'Risky Business' telling us this was a good way to promote learning and they felt able to contribute to its content. Learning from incidents was also discussed at the midwifery development days that occurred twice a year. One member of staff gave an example of this and we saw evidence of these sessions on the development day agendas.
- Staff told us they had received recent training on incident reporting as it was acknowledged that there was a degree of under reporting across the specialist services division. They told us that they had not always felt able to speak out about concerns in the past but they hoped this was now changing.
- During the past year the incidents reported by the Trust to the National Reporting and Learning System (NRLS) was low compared with other similar Trusts nationally.
- We found that although staff reported any incident that involved patients, non-clinical incidents were poorly reported. For example staff did not always report when they were understaffed, when consultants were late in attending or when the hospital's policies or procedures

were not followed for any reason. Staff said at study days and in training they were taught to always report when there was a lack of staff on a shift , however when they had done this they had been told not to by their managers. Others told us they did not report other type of incidents for fear of being stigmatised. The governance lead told us this was a training issue for the managers.

- The staff we spoke with could not give us examples where they had reported an incident and changes were made as a result. We spoke with midwifery staff who had worked at the trust for a long time who told us they had never had to report an incident although they knew how to. We also spoke with doctors who told us that they knew how to complete the electronic reporting tool but never did as that's what the midwives did.
- An independent review conducted by the clinical commissioning groups (CCG) in February 2015 found that there was a failure of staff in seeking support and escalating issues about lack of staffing. We found that although the trust was providing education and training about appropriate reporting practices there was still an element of fear of reprisals and anxiety when reporting non clinical issues.
- Staff felt the investigations and analysis of incidents was now thorough and comprehensive, however there were concerns raised about the learning and feedback not being anonymised. Staff felt there was a risk of 'naming and shaming' individuals which would not help improve reporting statistics.
- We spoke with consultants and senior managers, who told us about the clinical governance and risk meetings, which were held monthly by directorate.
- We saw minutes from the perinatal and maternal mortality meetings which showed that each incident was discussed amongst the relevant staff peer groups. There was no formal mortality and morbidity meeting in gynaecology. Any issues were reviewed as part of risk management meetings.
- Senior staff mentioned the Duty of Candour in discussions with us however we did not see evidence that staff at all levels were aware of their responsibilities under the new legislation.
- We did not see any information for staff relating to their responsibilities under the Duty of Candour and it was not mentioned in any of the team minutes we reviewed.
- We saw from the gynaecology investigations that the Duty of candour was discussed and appropriate contact made with patients where there were concerns of harm.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism. We found that the NHS Safety Thermometer information was available on Kennington Ward (Gynaecology) but not on the obstetric units.
- A maternity dashboard is used to record adverse maternal events such as eclampsia (Eclampsia is a life-threatening complication of pregnancy), haemorrhage, failed instrumental delivery, 3rd and 4th degree tears and admission to Intensive care units. Infant events such as unexpected admission to a special care baby units and birth injuries would also be recorded. The Trust was not using the maternity dashboard but was taking part in the Clinical Maternity Network pilot. A draft copy of the data used was available for the period April 2014 to March 2015.
- The performance data available indicated that the number of all caesarean sections performed at the hospital was slightly higher than the national average.

Cleanliness, infection control and hygiene

- There were infection prevention and control policies and procedures in place that were readily available to all staff on the Trust's intranet.
- In 2014 the Trust maintained its level 3 accreditation with the NHS Litigation Authority (NHSLA) Risk Management Level Three Standards. This included hand hygiene training and inoculation injury standards.
- We noted that the hospital's infection rates were consistent with the national average for bacterial infections such as MRSA and C. difficile during 2013/2014. There were no particular issues noted with infection in the maternity or gynaecology departments. The performance data available indicated that maternity related infections, such as puerperal sepsis (A serious infection related to giving birth) were within the expected levels.
- There was a designated midwife with infection control responsibilities. We were told that they regularly

undertook hand hygiene audits in order to make sure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE).

- All of the hospitals sites we inspected where patients were seen and treated were visibly clean and tidy.
- The Kent and Canterbury hospital was an older building and although the clinical areas were visibly clean, tidy and clutter free, the general environment was noted to be tired and difficult to keep hygienically clean. For example the ceiling in the day unit office leaked and the outside space next to the maternity unit was overgrown with weeds which could encourage vermin.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected. Disinfection wipes were available for cleaning hard surfaces in between patients. Once equipment was cleaned the contract cleaner labelled it to indicate it was clean and ready to use.
- Clinical and domestic waste bins were available and clearly marked for appropriate disposal.
- The cleaning of the hospitals was undertaken by an outside contractor. We saw that the linen cupboards were fully stocked and kept tidy, the cleaning equipment was colour-coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately by the contracted cleaners and checked by a manager.
- We spoke with the cleaners who were allocated specific areas and took pride in their area of work. They told us they had received good training which included infection prevention and control. Clinical staff at all locations told us the cleaners did an excellent job and provided a very good service. One midwife at Kent and Canterbury hospital told us the cleaner was "only too happy to help out and put something right when needed".
- Although in general we found equipment and clinical stock was in date and stored appropriately at the William Harvey Hospital storage was an issue with equipment kept in corridors. On Folkestone Ward sterile supplies were kept in a small cupboard with insufficient space to access safely.
- Equipment was marked with a sticker when it had been cleaned and was ready for use. However in the obstetric theatre recovery area we saw equipment that was not infection prevention and control compliant such as a blood gas analyser with dried blood on the outside of the machine and open computer keyboards.
- Areas where patients did not have immediate access were also cluttered, difficult to clean and a potential fire hazard such as the discharge administrator's room on Folkestone ward.
- We noted in the outpatient clinics, furnishings; such as chairs, were damaged, tired and required replacing. This presented an infection control hazard as damaged furniture is difficult to clean effectively.
- There were systems in place to test the quality of the water in the birthing pools to make sure it was safe. We noted that one pool had been out of action for 10 days as bacteria had been identified and following deep cleaning, repeat tests were being undertaken to ensure the water was safe before being used again.
- We found that staff generally were aware of the principles of the prevention and control of infection (IPC) and observed staff regularly use hand gel on entering clinical areas and between patients. The 'bare below the elbows' policy was adhered to and personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas.
- However at the Buckland Hospital we noted there was no hand sanitising gel at the entrance of the unit, which meant that visitors to the area could not clean their hands prior to entering the area. There was however hand-sanitising gel within the clinical rooms. We also noted one member of staff was wearing a bracelet, which meant that they were not compliant with the 'bare below the elbows' policy.
- All of the patients we spoke with across both the obstetrics and gynaecology wards told us that the hospitals were always kept clean and tidy. They told us they noticed the nurses were always washing their hands.

Environment and equipment

- At the previous inspection undertaken in 2014 we found there was a lack of medical equipment, particularly a lack of baby resuscitation equipment and CTG machines. CTG is used antenatally to monitor the baby heart rate over a period of time.
- During this inspection we found there was a lack of equipment across the obstetrics department. This

ranged from medical devices such as resuscitation equipment, fetal monitoring equipment and CTG devices to broken printers, photocopiers and electric fans.

- We were told there was a rolling programme to replace equipment. However although some equipment had been replaced, staff told us there was still not always enough working equipment available. The lack of equipment was an issue raised by several midwives who said they had to "beg, borrow and steal". In the day care unit midwives told us that although some of the equipment such as sonicaids were old, they still worked.
- We were told that there was a particular issue with theft of medical equipment across the county and staff gave several examples where medical equipment had been stolen. In order to address this issue locked equipment boxes were due to be installed in clinical areas. The hospital had also implemented an equipment library, which staff told us had helped with the availability and reliability of some of the equipment.
- The CCG report in February 2015 documented that lack of appropriate available equipment had featured as a contributory cause in a number of serious incidents over the past year.
- We reviewed the testing and maintenance of equipment such as resuscitation trolleys and resucitaires (resuscitation equipment for babies), CTG machines, sonicaids (a handheld device midwives used to detect a fetal heart beat), medicine trolleys and fridges, etc. Equipment was labelled following portable appliance testing and cleaning to indicate that it was fit for use. The majority of equipment we saw had been labelled to verify it had been electrically tested within the past year. We saw that staff documented equipment checks in the ward diary. We noted there with few exceptions that equipment was usually checked appropriately. However we found a CTG machine in the day care unit at William Harvey Hospital was labelled as next requiring servicing in September 2014.
- At the Buckland Hospital we saw equipment such as thermometers, blood pressure machines and sonicaids, which had out-of-date labels on them. One midwife told us it was difficult to coordinate the servicing of equipment as it was often being used in the community, when servicing was being carried out. There was one CTG machine available to use. Staff told us that they used to have two of these machines but one had been condemned and they were waiting for it to be replaced. This resulted in some women being sent to the William Harvey Hospital for monitoring
- We saw there was adequate adult resuscitation equipment available in both the obstetrics and gynaecology wards. However this was not always checked daily.
- There were concerns that in the midwife led unit there was only one infant resuscitaire which was not moveable. The resuscitaire was fixed to a wall of the treatment room with the baby weighing scales stored underneath. NICE guidelines recommend that there is minimal separation of the baby and mother. Taking the baby to another room for resuscitation does not meet with this guideline and is not recognised as best practice. Using the treatment room for resuscitation purposes meant that if another patient required a dressing or medication the room would be inaccessible if a baby was being resuscitated.
- At the Buckland Hospital the adult resuscitation equipment was shared with and located within the renal outpatient department, which was located next to the maternity unit. Although the hospital did not include a delivery area, emergency equipment for the delivery of a baby was available.
- At the Kent and Canterbury Hospital resuscitation equipment was readily available in corridor.
- We found that the environment did not always provide a safe place to look after women. For example there was a single obstetric operating theatre for both emergency and elective procedures. There was no second dedicated theatre. This led to frequent delays to the elective caesarean list and could cause delay in the treatment of emergency patient. Although a second theatre in the main theatres could be made available, this was not always possible. In extreme circumstances an emergency operation was performed in the obstetric anaesthetic room if no other theatre available.
- Across the hospital there was little space for storage which meant equipment was often found in corridors where it restricted access and created potential hazards.
- We found that the midwife led unit could not always be kept secure as the fire escape from the neighbouring ward exited through the unit. We were told that on

occasions confused patients from the ward next door accessed the ward through the fire exit door. This was a security and infection control risk for the Singleton unit which was a secure unit caring for mothers and babies.

Medicines

- At the last inspection we found that medicines were not always stored and managed safely. We found several medicine cupboards and clinical fridges unlocked.
- The Trust told us they now conducted two medicine audits each year. The results of the audits indicated that there had not been any significant improvement in compliance.
- At this inspection we noted an improvement in medicine management however there were still some practice which did not meet current best practice or comply with national guidelines. The staff we spoke with were aware of the Trust's medicine management policies, which were readily available on the intranet. For example although the Trust had guidelines on the use of patient group directives, they were not often used and were either not available or were out of date.
- Since the last inspection there was an improvement noted in the security of medications with digital locks now on the drug cabinets and the controlled drug cupboard key held by the nurse in charge. However on the day care ward at the William Harvey Hospital the drugs fridge was unlocked in a patient area and the medicine cupboard was unlocked in the staff office. On Folkestone Ward medications were prepared and stored in the corridor as there were no treatment room facilities. Sterile packs and infusions were also stored in cupboards in the corridor which were noted to be overfull and congested.
- Controlled drugs were checked twice daily and this was documented. We observed controlled drugs being checked safety and being disposed of appropriately when not required. However we noted that the controlled drug book kept in the midwife led unit had been started in 2009 and was now at risk of falling apart with loose pages.
- The controlled drugs policy had been rewritten and now required two signatures to sign for all controlled drugs. A monthly audit demonstrated an improvement in compliance from 59% in month one to over 80% compliance in month three.
- On Kennington Ward (Gynaecology) staff told us that because of staffing shortages there was sometimes a problem in having two registered nurses to check controlled drugs. This was an issue especially at night.
- Medicine fridges were checked daily apart from the day care unit at the William Harvey Hospital where temperature recording was noted to be erratic. We did not see that the ambient room temperatures recorded in any area where drugs were stored. This was a particular issue on the labour ward when room temperatures were regularly recorded over 28°c. Many medicines become unstable or deteriorate when stored over 25°c.
- On the midwifery led unit we found some medication that had expired. This was destroyed by the ward manager immediately
- We reviewed a sample of medicine administration records which were completed appropriately.

Records

- The Trust was using a mainly paper-based record system, supplemented with electronic records. Standardised obstetric records were in place that tracked the patient's journey through initial booking to post delivery. We did not see any audits of record keeping.
- Patient observations were undertaken with an electronic system that automatically uploaded patient observations. This gave doctors access to test results so appropriate treatment could be arranged quickly. Staff told us that the trust's electronic-based system was very efficient with information, regarding viewing tests and investigations which were available online.
- The midwives in the community using were using electronic tablets to record patient care and make appointments. We were told that although when it worked it was very useful it was very dependent on a good Wi-Fi signal and this didn't happen over much of Kent which was rural and had poor coverage. The electronic tablets were not compatible with the Trust's IT system which meant that the midwives could not always access the Trust's system through their tablet; we were told that the IT department was aware of the issues and working with the department for solutions.
- The system for electronically issuing new born babies with NHS numbers wasn't working. All babies require an NHS number within 4 days of birth as they usually undergo a screening test on the 5th day for which the

number is required. This meant that midwifery and administration staff were spending a lot of time manually allocating numbers. There was a risk that babies were could miss the new born screening test if the number had not been allocated appropriately as the NHS number is the key identifier for the baby.

- We noted that a number of serious incident reports over the past year gave incorrect or incomplete records as a contributory cause. For example midwives not accurately recording woman's history or the telephone enquiry sheet not being fully completed.
- On each ward, unit or clinic we reviewed a small sample of nursing and medical records. We found the majority of the records were clear, concise and recorded appropriate information in a logical and legible format. Entries had been dated, signed and timed appropriately. The birth plans we looked at recorded the women's' preferred wishes such as 'happy to have student midwife present' and 'husband to cut cord if possible.
- We noted that the maternity records were kept in a loose leaf format where there was a risk that individual pages could get lost or miss-filed.
- At the Buckland Hospital one set of records we reviewed contained loose pages, which could have easily been lost. Another set of records had information missing. For example no plan for the delivery and inaccurate information had been recorded on the CTG. This could have resulted in the woman receiving inappropriate care.
- At the Kent and Canterbury Hospital we spoke to women in late pregnancy who told us they did not have a recorded birth plan. Staff told us they would 'do the birth plan at 36 weeks'.
- The labour ward used a triage form when women in labour contacted the ward for advice or to be admitted. However the triage form was not always completed appropriately with 14 of the 37 triage forms currently in the folder not having been signed by the member of staff giving patients advice.
- The hospital used the adult surgical pathway for any woman who required surgical intervention for either obstetric or gynaecology procedures. All but one of the surgical records we reviewed were fully completed and included completed World Health Organization (WHO) surgical safety checklists. We found one set of records at a post natal clinic where the WHO surgical safety checklist, a five step set of safety checks initiated at critical time points during a patient operation, had not been completed.
- We were told that the paper scanning cards often got lost meaning that appointments were missed. The community matron told us how a generic email account had been created for booking obstetric scans which was checked hourly. This had resulting improved booking and staff gave positive feedback as there was now an audit trail of scanning requests. However the risk register documented that although this system worked extremely well in the past month the midwives have had no response to the emails and have been told this out of service due to staffing issues in the radiology department.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on its intranet.
- The midwifery department had a safeguarding lead, who acted as a resource for staff and linked in with the trust's safeguarding team.
- Midwives assessed social vulnerability when women were initially booked into clinic. Extra information was requested from a woman's GP or social services if necessary. Midwives gave women information about relevant support services, (for example about substance abuse, sexual abuse of under 16s or a violent partner).
- Safeguarding training was included in the trust's mandatory training programme. We were told that all staff undertook basic safeguarding training. Those staff with additional responsibilities undertook level two and three training. The results of mandatory training indicated that 91% of staff at the William Harvey Hospital had undertaken child protection training.
- Staff told us that training on FGM (female genital mutilation) formed part of the unit's mandatory safeguarding training. All the staff we spoke with knew how to escalate concerns if a female baby was flagged as high risk
- Staff we spoke with told us that they had received safeguarding training as part of mandatory training. One staff member gave an example of what they would do if they had concerns regarding unexplained bruising.

- There had been one safeguarding allegation against the Trust during the past year for the William Harvey Hospital. This was appropriately investigated according to the Trust's policy linking in with the local authority safeguarding team.

Mandatory training

- We looked at the staff mandatory training records and identified there was a good uptake of training for the maternity and gynaecology departments. Between 88 – 91% had attended Midwife development days which included child protection
- We spoke with consultants and doctors of all grades. They told us that mandatory training, such as safeguarding and infection control, was available, although it was not always easy to find the time to attend. 52% of doctors at the William Harvey Hospital had attended the 'Skills Drills' training.
- Although we were told that the hospitals tried to use the same agency staff that were familiar with the Trust there were concerns raised that there wasn't an orientation pack for agency staff new to the wards.
- At the William Harvey Hospital 93% of staff had completed their Skills Drills training which included: moving and handling, maternal and neonatal resuscitation skills, obstetric emergencies and mental health issues. We spoke with staff who confirmed that training was readily available however there was not always time to access it. Midwives and doctors were taught together at the monthly 'skills drills' sessions
- We spoke with an anaesthetists who told us they ran live 'Skills Drill's' training on a regular basis. They told us the next one due was in September and was about obstetric emergencies such as haemorrhage.

Assessing and responding to patient risk

- The trust used a modified early warning score (MEWS). This scoring system enabled staff to give early identification of patients who were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patients risk such as the Malnutrition Universal Screening Tool (MUST) and the venous thromboembolism (VTE) assessment tool to identify those at risk from developing blood clots.
- We saw examples of staff in the labour ward and midwife led unit using the MEWS system to identify deteriorating patients and ensure that they were seen quickly by a doctor. At Buckland Hospital we saw one example where the MEWS and VTE assessment had been performed and one where it had not.
- The William Harvey Hospital had a 25 bedded neonatal intensive care unit which was able to care for new-born babies from around the county who required increased support up to Level 3.
- We noted that the transfer from midwifery led unit to consultant led unit was 50%. The midwives we spoke with told us this was high and the consultant midwife investigating the reason behind this.
- Staff on Kennington Ward (Gynaecology) told us that an outreach team visited the ward each weekday to provide support for deteriorating patients
- The use of additional beds without appropriate staffing on Kennington Ward(Gynaecology) for outliers was raised as a risk in September 2013 on the divisional risk register. Although the number of beds used has been reduced there remained four unfunded beds still in use. This is due to cease once the Gynaecology Assessment Unit becomes operational in August 2015.

Midwifery staffing

- At the last inspection we found there were gaps in staffing due to vacancies, secondments, and maternity leave. Staff had been "acting up" to cover vacant posts for a significant period without having been formally recruited to.
- At this inspection we found that although the midwife birth ratio had improved, there continued to be a number of vacancies across the maternity and gynaecology departments. The Trust's inability to safely staff the acute sites at times of high activity or unanticipated staffing issues was raised on the divisional risk register.
- In February a CCG report indicated that the Trusts publication of nurse staffing data showed significant gaps in staffing levels over the past year. The Singleton Unit was noted to have been significantly under staffed in November and December 2014 due to a combination of sickness and vacancies. The fill rate for the maternity care assistants was under target from May 2014 to January 2015. This had potentially impacted on patient care as the wards with the highest reported staffing difficulties were amongst the highest reporting ward of medicine management incidents.

Maternity and gynaecology

- The wards did not use a 'Safe Staffing' board. We were told by senior managers that the Trust was currently undertaking a review of acuity to assess the current level of staffing provision. The results would be independently verified by the Local Supervising Authority (LSA) and appropriate action taken to address the findings.
- Managers told us that agency and bank nurses were now used to cover vacant shifts, however there were still occasions where there were insufficient staff on duty. On the day of our inspection several shifts were covered by agency staff and managers gave examples of 27 shifts requiring cover next week. However managers tried to book the same agency staff who were familiar with the ward. They told us that the bank staff were usually staff already employed within the midwifery department. Staff told us that they now used agency staff which was an improvement on the previous year when agency staff were not allowed. Staff were moved between wards and units and on occasions community midwives were brought in to support the hospital service.
- At the previous inspection the birth ration was 1:33. This had now improved to 1:28 which was the national standard ratio of midwives to births.
- Staff told us there was a problem recruiting in the area. They told us that posts had been advertised but no one had turned up for interview. Managers told us that a number of appointments had recently been made such as two band seven nurses appointed on Folkestone Ward.
- We were told that over 50% of staff had been granted flexible working patterns which had led to considerable problems when organising safe cover for the obstetrics department. There had recently been a change in the policy for granting flexible working as this was unsustainable. However change to working patterns was causing additional staff unrest made worse by the 'impersonal' e-rostering which did not take into account personal circumstances when allocating shifts.
- Across the Trust we were told that clerical and administrative staff had left and not been replaced. This was putting additional burden on the existing staff and meaning that midwives and midwifery healthcare assistants were undertaking more administrative work. Staff told us it was very frustrating being called away from the patients' bedside to undertaken administrative tasks.
- At inspection we found that there were still issues related to staffing which impacted on patient care. For example on Folkestone Ward staff were often tied up undertaking discharges which meant there was insufficient time to care for women appropriately or support them with breast feeding. On the Singleton Unit and Kennington Ward (Gynaecology) we found that there was insufficient nursing and midwifery staff to allow staff to take breaks. Staff raised concerns about the staffing levels on the labour ward during the night. They told us the issues had been raised through the incident reporting system but remained a concern.
- On Kennington Ward (Gynaecology) staff told us that a four bedded bay had been open since Christmas. This was a problem as there was no funding for extra staff to care for the additional patients. We saw that this was on the divisional risk register.
- Staff told us that on Kennington Ward (Gynaecology) they didn't often get to take their breaks because short staffed. They gave an example where the previous week the ward was staffed with one qualified midwife and one healthcare assistant. This meant that staff couldn't take breaks or leave the ward. One staff member told us "Staffing is shocking". They told us this was a particular concern as the ward was shortly going to be starting a gynaecology assessment unit without any extra staffing allocated. Staff across the unit were concerned that this would leave the general gynaecology ward short staffed.
- On the day of our inspection the day care unit at the Buckland Hospital was one midwife short due to sickness. This meant that that midwives from the antenatal clinic were required to help staff the unit as well. One midwife told us that this often happened and it resulted in having to rearrange appointments with women in the community. All the midwives we spoke to reported they were short of staff and felt under pressure. One member of staff commented 'everyone is stressed out – it is not a happy place'. Staff told us that they frequently missed breaks and were late leaving work and did not get paid for any extra hours they worked. Midwives felt that they were often rushing women and not able to offer the quality of care and support they would have like to. Midwives told us that sometimes they could not provide continuity of care, which mean that women did not always see the same midwife. They said they were often late in processing the women's records.

- At the Buckland Hospital there was no member of staff in the reception area. The staff member who covered the reception was also required to file patients' records. Patient records were kept in a room away from reception so the reception desk was left unmanned when filing was undertaken.
- Band seven managers told us that because of the recent issues where a number of senior staff had been suspended, they were called at short notice to work across wards and departments. Although they said that they didn't mind this they felt it was leading to lack of consistent management and unrest. We were told that the labour ward coordinators did not often have supernumerary status, which was raised as a risk on the divisional risk register.
- The trust employed two consultant midwives however we found that this resource was not being used effectively. We met with one consultant midwife but were unclear about her role as a consultant in supporting staff. Midwives and doctors on the wards and in the community told us they did not see any impact from their appointment. They told us the consultant midwives were not visible and it's more of a management post really; it doesn't impact on us at all'. Consultant midwives would usually be used to help modernise the service working directly with patients and developing practice through research, education and development.
- Specialist midwives were available to support patients and act as a resource for staff. These included specialists in screening, fetal medicine, teenage pregnancy, bereavement and the care of vulnerable women. There were lead midwives for health and safety, infection control and catheter care.

Medical staffing

- This trust has a slightly larger proportion of Consultants and middle career doctors than the England average, however it had been identified that additional consultant cover was required to address antenatal and labour ward cover. A business case for two further consultants had been approved. The clinical director told us this would facilitate the antenatal clinics and cover for a second obstetric operating department in the future.
- The CCG Report undertaken in February identified that having a single registrar on nights covering the level three neonatal unit, the acute paediatric ward, the high risk maternity unit and the emergency department contravened the recommendations of the British Association of Perinatal Medicine and the Department of Health Toolkit for high quality neonatal services.
- The report also highlighted issues where a registrar failed to ask for support and escalate concerns about a patient to the consultant on call. The doctors we spoke with told us that they would have no problem in asking for support from the consultants if needed and gave examples where they had done so.
- The clinical director for women's health told us that the medical cover for the labour ward was good with 70 hours of consultant hours which included seven day cover. This was confirmed by the consultants we spoke with. However we found that the consultant presence in the department was not solely for the labour ward as recommended by guidance issued by the Royal College of Gynaecologists, but included the elective caesarean sections operating list, cover for the gynaecology ward and the emergency department.
- We spoke with consultant anaesthetists who told us there was cover for the obstetric unit Monday to Friday with weekends covered by an emergency on call rota.
- The middle grade doctors told us that the hospital felt short staffed both for junior doctors and midwives. The available data confirmed that although the Trust employed slightly lower percentage of registrars there was a higher number of junior doctors than the England average. The midwives we spoke with told us that there was generally no problem in obtaining medical opinions and they always received a prompt response from the medical team when they had concerns. However they also told us that medical reviews prior to discharge took a long time because there was often not enough doctors available.
- Staff on Kennington Ward (Gynaecology) told us that medical cover for the ward was good although they shared medical cover with the maternity department. They told us that on the odd occasion when a doctor hadn't come when requested an incident form was completed but it wasn't usually a problem.
- However the patients we spoke with on the gynaecology ward told us that they hadn't seen much of the doctors. One patient told us that a patient had asked to see a doctor the previous night but they still hadn't come by the following day.

Major incident awareness and training

Maternity and gynaecology

- East Kent University Hospitals NHS FT was located in an area with several high profile locations where major incidents may occur such as the ports, international rail links, Channel Tunnel and airports.
- The trust had a major incident policy with robust measures in place to deal with major incidents and maintain public safety. We were told how regular training took place on responding to major incidents alongside of other emergency services, health and social care providers. Two live exercises were planned for 2015.
- Staff were made aware of the Trust's Major Incident Plan through electronic and paper means. The policy was available on the Trust's intranet with hard copies and posters issued to 114 areas throughout the Trust.
- The trust had business continuity plans in place for all hospitals, including the William Harvey Hospital, Kent and Canterbury Hospital and the Buckland Hospital. These included communication details and useful telephone numbers.
- There was an escalation policy in place to ensure a standardised approach when diverting women to the other acute site or when both maternity units were closed. The maternity units were closed or diverted 88 times in the past year. The reasons for this were where the staffing levels or bed capacity did not allow for further admissions or the neonatal facilities were full. During the inspection a 'divert' was in place for a short period due to the special care baby unit being full. The number of closures and diverts was raised as a concern at the last inspection and we saw there had been little change at this inspection. Because of lack of capacity or staffing women were still regularly diverted 30miles between the Trusts two main birthing hospitals or further afield to other Trusts.

Are maternity and gynaecology services effective?

Requires improvement

Maternity and gynaecology services at the William Harvey Hospital were rated as requires improvement in terms of delivering effective care.

Although the hospital was not using a maternity dashboard the data was being collected. However the information was not yet being collated and used to inform maternity services. Audits were taking place across both obstetrics and gynaecology wards however the lack of a midwives with auditing responsibilities and the leadership issues over the past year meant that there had been a loss of focus on improving the quality of maternity care through robust auditing. There had not been any auditing of compliance with the Trust's policies or best practice guidelines.

We found that although the inpatient wards and community midwives offered a seven day service they were not always supported by other services such as radiology. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

We found that in general training for staff across the obstetrics and gynaecology services were good with newly qualified staff being well supported. There was still a shortage of midwifery supervisors but the situation was improving. The hospital had undertaken a considerable amount of work in reviewing and updating the policies to ensure they were up to date and met best practice guidance. The policies were readily available to staff through the Trust's intranet.

There was effective multidisciplinary working both within the hospital and with outside agencies. Breast feeding across the Trust was well supported. The hospital had achieved stage one accreditation in the Baby Friendly which demonstrated that there were systems in place to promote breast feeding.

Evidence-based care and treatment

- At the last inspection we found that the clinical guidance and policies used by staff were out of date. Since then considerable work had been undertaken on reviewing and updating the policies. There was a midwife in post with responsibilities for ensuring the guidelines were up to date. We were told by the clinical governance lead that there were now only 6 policies that required updating and these were in hand awaiting medical input.
- We reviewed a wide sample of policies and procedures and found them to be up to date and reflected current best practice and national guidance. For example the hospital's policy for caesarean section referenced best practice guidelines from the Royal College of Obstetricians and Gynaecologists, the Centre for

Maternal and Child Enquiries (CMACE), the National Institute for innovation and Improvement, the National Collaborating Centre for Women's and Children's Health and the National Institute for Health and Clinical Excellence (NICE).

- Staff were able to access national guidelines through the trust's intranet, which was readily available to all staff. Midwifery staff demonstrated the ease of accessing the system to look for the current trust guidelines.
- The local CCGs undertook a review of the maternity services in February 2015 where it was noted that there were unclear guidelines and processes in place. The CCG's investigation of serious incidents had concluded that staff on occasion had failed to follow guidelines. We noted that there had not been any auditing of compliance with the Trusts policies or best practice guidelines.
- The trust had recently commissioned an independent service review by the Royal College of Gynaecologists and Royal College of Midwives to start during the summer and had appointed a senior midwifery manager from a neighbouring trust to support the acting head of midwifery and start a problem solving exercise to help to identify issues within the obstetric division and look at improving service delivery.
- The specialist services division had produced clinical audit plans which were presented to the Clinical Audit Committee and signed off by the Quality Committee in April.
- There was a local audit programme in place to monitor the quality of care and treatment. The monthly specialist services audit programme report identified that in May 2015 there were 34 women's health audits to be undertaken during 2015/2016. However the trust did not have a midwife with responsibilities for overseeing the audit programme and we noted that there were six obstetric audits behind schedule and nine waiting to be registered.
- We found some local auditing had taken place during 2014/2015 although there wasn't a dedicated audit midwife in post. For example we noted an anti-natal audit of screening data 2014/2015 had taken place. This included data for sickle cell and thalassaemia, infectious diseases, Downs Syndrome and fetal anomalies. The audit identified at 13% had missing information on form.
- A report on the progress of the 2014/2015 audit programme identified that gynaecology services had conducted six audits with obstetrics undertaking 40 audits. A number of the obstetric audits were abandoned due to insufficient data or relevant staff leaving although collecting the data was a national requirement. The Trust provided a list of audits due to take place during 2015/2016. We noted that gynaecology services had listed two of the 18 audits proposed and the majority of audits had not started.
- Doctors told us about monthly 'audit days' which were attended by the doctors and senior management team.

Pain relief

- In the maternity services midwives told us there were no problems in obtaining pain relief or other medication for women. All the women we spoke with who had recently given birth told us they had received pain relief as required.
- On Kennington Ward (Gynaecology) staff told us that one of the more common complaints was the delay in pain relief. The staffing situation meant that there was often only one qualified member of staff on duty and as two qualified staff were needed to check controlled drugs this led to delays in women accessing prompt pain relief. This was confirmed by one of the patients we spoke with on the ward who told us that it took three hours for pain relief to arrive, as the ward staff were waiting for a second nurse to be available to check the drugs.

Nutrition and hydration

- Women on the antenatal, postnatal and gynaecology wards said they were satisfied with their meals. Women told us that although the food was "OK" they had been grateful for the toast and jam and a cup of tea. Light refreshments were also offered to the women's partners. There were facilities for making toast and light snacks in all the inpatient units.
- Staff told us that snack boxes were available for women to ensure that whatever time of day they felt hungry food was available. We observed snacks, biscuits and fruit available on the mid-morning drinks trolley
- On Kennington Ward (Gynaecology) the patients told us that the meals were good and there were plenty of snacks available if required. They told us they could request smaller or larger portions if needed. We saw that relevant patients had nutritional assessments and dietary supplements.

- Mothers on the postnatal ward were pleased with the support they received with breastfeeding their babies.
- We spoke with the dedicated breast feeding midwife who worked across the hospital sites. She told us about the support offered to new mothers and was proud to tell us that the hospital had achieved stage one accreditation in the Baby Friendly Initiative which is a UNICEF programme to promote breast feeding. Stage one accreditation demonstrated that there were systems in place to promote breast feeding.

Patient outcomes

- The Trust was not using the maternity dashboard developed by the Royal College of Obstetricians and Gynaecologists to help obstetric services to plan and improve their maternity services.
- Although the Trust was not using a maternity dashboard they were taking part in the Clinical Maternity Network pilot. A draft copy of the data used was available for the period April 2014 to March 2015. The information provided gave some basic data for obstetric care across the Trust. It did not identify individual hospitals, always give percentages and did not include metrics for safe care or red flags which alerted staff to possible problems. For example from the data provided it couldn't be identified if the booking targets were being met or if the number of incidents of shoulder dystocia was within acceptable limits. Shoulder dystocia happens when the baby's head has been born, but one of the shoulders becomes stuck
- We looked at the data collected for the previous two months and noted that information was collected on all birth statistics and was then available to inform clinical governance and strategic planning. For example in June 282 births took place in the consultant led unit, 68 on the midwifery led unit and 17 took place at home. In June there were no water births in the consultant led unit but 27 in the midwifery led unit and two water births at home.
- We saw that the proportions of delivery methods for example normal delivery and assisted delivery using medical devices were similar to the national averages.
- However the caesarean section rate was higher than the national average of 23%. The proportion of caesarean sections for 2014/2015 was 26.6% with 15.1% emergency and 11.5% elective caesarean sections.
- The number of women with third and fourth degree tears was noted to be around the national average of 2.9% for unassisted deliveries but was 6.8% for assisted deliveries. The Royal College of Obstetricians and Gynaecologists states the overall incidence in the UK is 2.9% (range 0–8%).
- Between April 2014 and March 2015, 51 women suffered a severe postpartum haemorrhage (blood loss during or immediately after birth) which was within acceptable national limits
- The hospital recorded that 5.5% of women or their babies were readmitted as an emergency following discharge from the hospital.
- All women who were assessed as low risk were given a choice to deliver their baby in the midwife led unit. Approximately one third of women who started their labour in the midwife led unit were transferred to the consultant led labour suite during labour. Staff told us this was due to the criteria used to admit women to the unit.
- The William Harvey Hospital performed poorly in the National Neonatal Audit Programme 2013

Competent staff

- The midwifery staff we spoke with told us that in general training and support was good. They told us that there were no problems with accessing training. All mandatory training was provided through e-learning but some staff. Training was a mixture of on-line and face to face practical training which worked well. They told us that staff were allocated time to undertake the training.
- The Trust told us they had recently started a new induction process for new staff.
- Midwives were required to complete two development days per year. These were arranged by the Practice Development Midwife. One of these days was running at the Buckland Hospital the day we inspected. We saw the agenda for the last two of these development days which included updates on Female Genital Mutilation and mental health issues. One midwife reported these days were beneficial.
- The maternity service supported the newly qualified midwives in achieving competence in clinical skills by the support of clinical skills facilitators. These were more senior midwives who helped teach and assess the junior midwives with their clinical skills.

- Staff told us they would only use equipment, for example for blood pressure and blood sugar monitoring, once they had training on it and were familiar with it.
- However a member of staff in the early pregnancy unit told us they wanted to undertake further training so that they could perform ultrasound scans, but had been told there was no funding available for this course.
- Staff told us that the Trust was currently using a lot of agency and bank staff, and that although they always tried to use the same agency staff, there was no robust system in place for checking their competencies for example drug administration competencies.
- Throughout the all three hospitals we inspected we found that the majority of staff had received their annual appraisal. 84% of staff at the William Harvey Hospital had received an appraisal by June 2015. All of the staff we spoke with had completed their annual appraisals.
- All the medical staff we spoke with were aware of their revalidation dates, and told us that they had had appraisals in the past year.
- Midwives have a statutory duty to undertake regular supervision with a supervisor of midwives. There should be one supervisor of midwives to every 15 midwives and her role is to protect the public through the safe provision of evidence-based midwifery care. We were told that there had been a problem in having enough supervisors for the number of midwives and that on occasion the ration had risen to 1:20. However the managers and supervisors we spoke with told us that the situation was improving. One new supervisor told us how she had been supported in her new role with a low caseload until she was ready to increase the number of midwives who reported to her.
- We spoke with the doctors, who told us that training opportunities were available but staff shortages meant they could not always attend.

Multidisciplinary working

- The Trust had policies which promoted multidisciplinary working. Communication was encouraged to encourage health and social care professionals to work together.
- At the Kent and Canterbury Hospital we spoke with the midwifery liaison officers who demonstrated how they worked with all the involved agencies in both the hospital and community settings to provide a seamless package of care for women and their families. The community matron praised this service and the staff working in it, as for some time they had been working without direct management support but had continued to offer an exemplary service without supervision.
- The minutes from the perinatal and maternal morbidity meeting demonstrated effective multidisciplinary working. For example a patient with multiple medical conditions successfully delivered a baby with the support of the renal and diabetic teams. Where improvements were identified these were taken forward. This demonstrated good communication and multidisciplinary team involvement.
- Staff told us that the medical and midwifery staff worked well together. Although we were told that ward rounds and handovers included midwives on Folkestone Ward we saw that there were medical reviews of patients taking place without a lead midwife for the patient being present. On the labour ward we observed a doctor telling midwifery staff that they had seen a patient and she was now ready to go. There was no record of what was discussed, any issues raised or the arrangements that had been made.

Seven-day services

- At the William Harvey Hospital the consultant led labour ward, the Singleton Unit, Folkestone and Kennington Ward (Gynaecology) were open for 24 hours throughout the seven day period.
- The day care unit at the William Harvey Hospital was open seven days a week. Monday to Friday 8am to 8pm and 8-4 at the weekends. Women were given contact numbers for each of the maternity departments and labour wards where there were staff available to answer questions and provide advice.
- At both the Kent and Canterbury and Buckland hospitals the maternity day care units were open seven days a week, from 9am to 5pm. The early pregnancy unit was open Monday to Friday.
- Women were able to access emergency care by reporting to the emergency department. However the gynaecology ward was about to start an emergency assessment unit for urgent gynaecological care.
- However, we found that not all of the support services offered a comprehensive seven day service.
- Midwives and doctors told us that although the radiology service offered an out-of-hours service, in

reality, it was very difficult to emergency X rays done out of hours. Staff gave the example of difficulties when accessing emergency interventional radiology service for women who have a major postpartum haemorrhage. There was a known capacity issue with the radiology department. The Trust was aware of these issues which appeared to the department's risk register.

Access to information

- The majority of locations where women were seen and treated had a wide range of information readily in the form of leaflets, booklets and posters. These included general information on the ward, information on various conditions, and support groups in the community, together with public health information. For example Folkestone Ward had lots of information that was bright, eye catching, informative and easy to read.
- However we noted that in other areas such as the antenatal area there was minimal public information available for patients. The available space on the notice boards was taken up with advertisements for private healthcare scans and photographs. We noted this was a missed opportunity for health promotion.
- The hospital produced a booklet for patients who had experienced bereavement. However this booklet was for people who had lost an adult and was not appropriate for women and their families who had lost a child. For example the booklet describes how to access the deceased property and jewellery, the documents needed such as the deceased utility bills and driving licence, viewing the body in the mortuary and talking about the deceased life and accomplishments. Receiving this type of impersonal literature following the loss of a baby does not demonstrate personalised care or acknowledge the families distress at losing a child.
- The hospital's website also provided information, and signposted to further sources of information and helpful advice.
- Staff told us they gave written information to the women using the service about the tests performed. However one woman said that she had not received any leaflets.
- There were 'Parent craft' sessions held once a month, where mothers could get support and help prepare for their baby's birth, breastfeeding and aftercare.
- One woman we spoke to had attended an antenatal class but felt that it was that too was rushed. She said the class had started late and finished two hours early. This had left her feeling very anxious about what was going to happen in labour.
- There were notice boards around the hospitals which gave information for staff about training opportunities, staff meetings minutes, and the results from audits and incidents. Some information was out of date for example newsletters and audits dated 2013.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Staff told us that training on the MCA 2005 and Deprivation of Liberty Safeguards (DoLS) was available and the Trust had held conferences on the MCA and DoLS. However from the training data provided it couldn't be verified that staff had attended this.
- There had been no deprivation of liberty application for the women's health services in the past year.
- The inpatient wards had information on the mental capacity act 2005 available including how to assess capacity for day to day decisions.
- Kennington Ward (Gynaecology) took medical outliers and this sometimes included confused patients or those living with dementia. A dementia link nurse was available to support the staff if needed.
- The majority of staff were able to describe the process of obtaining valid consent, but were less familiar with the DoLS.
- Staff we spoke with did not always understand the MCA 2005 and had not attended training. They told us that they would ask the trust's safeguarding lead, who assumed overall responsibility for the process.

Are maternity and gynaecology services caring?

Good

We rated the maternity and gynaecology services at the William Harvey Hospital as good for caring, because the

majority of women and their partners we spoke with, or who contacted us, were positive about their experience of the care provided to them, and told us they were treated with kindness and compassion. There were exceptions where women felt they were not treated with kindness or understanding during their pregnancy or the birth of their baby.

During our inspection of both obstetric and gynaecology departments we observed staff being friendly towards patients, and treating them and visitors with understanding and patience, and observed treatment that was provided in a respectful and dignified manner.

Women across women's health services told us that they were usually involved in decisions about their care, and were kept up to date with their progress. Gynaecology patients told us how impressed they were with the ward and how efficient it was and how well staff explained everything to them. Emotional support was provided by staff in their interactions with patients, together with support from specialist lead midwives where indicated.

Most patients and their relatives were positive about their experiences, with comments such as "A fantastic experience" and "Midwives are amazing – they get you through labour, you feel safe".

Compassionate care

- We spoke with 14 women and five of their partners currently receiving care, who all told us they had had a "Really good experience" and that the care at the William Harvey Hospital was "brilliant" throughout. Women who had recently given birth told us they had had "A fantastic experience" and that the midwives were "Midwives are amazing – they get you through labour, you feel safe"
- Women at the Kent and Canterbury and Buckland hospitals had nothing but praise from their first antenatal appointment to the safe delivery of their baby.
- On Kennington Ward (Gynaecology) the women receiving gynaecological interventions told us that staff were very kind and attentive.
- Before the inspection women contacted us to tell us about their birth experiences. The majority of women had positive experiences and they told us staff were "amazing", "considerate", "friendly" and "kind". One woman told us "I'll definitely have my next baby here"
- Although the majority of women had positive experiences, some women told us that staff in the antenatal clinic and antenatal ward had not been sympathetic and on occasions "appalling". One woman told us that they were made to feel like an "inconvenience" and that staff on the maternity day care unit had treated her without any compassion or empathy. Another woman told us she had little support and was made to feel a "Burden".
- During our inspection, we saw staff talking with patients in a respectful and caring manner, taking time to explain options to patients.
- Patients told us that they were treated with dignity and respect by all members of the care team. We observed staff knocking on doors before entering, and curtains being pulled around beds before treatment or private conversations took place.
- The Friends and Family test scores for maternity at East Kent University Hospitals FT EKHUFT were overall in line or above the England average. The highest scores were within the post-natal and community setting and the lowest scores were from the post-natal ward.
- We saw that Friends and Family information was displayed on notice boards around the wards and departments however we noted the information displayed was five months out of date.
- The Trust scored 'the same as other trusts' in the majority of questions in the 2013 CQC survey of women's experiences of Maternity Services.

Understanding and involvement of patients and those close to them

- In the 2013/14 CQC survey of women's experiences of Maternity Services the trust scored better than other trusts in respect of mothers being given appropriate advice and support at the start of their labour and the involvement of their partner during labour and birth.
- We spoke with women who had recently given birth. They told us that they had been kept informed during the labour and said that the Midwives were really kind and explained everything. They told us they had received lots of information and help with breast feeding.
- In the antenatal clinics women told us they had no problems with the service provided. They told us they

were given convenient appointment times and were general seen close to this time, everything was explained and the consultants "approachable and down to earth".

- We spoke with the partners of two women in the antenatal clinic at the Buckland Hospital. They told us they were pleased that husbands and partners were allowed to stay overnight.
- However a woman at Kent and Canterbury hospital was distressed that there would be men staying overnight on the post natal ward. They had not yet raised their concerns with their midwife for including in their birth plan.
- Two of the women in late pregnancy we spoke with at the Kent and Canterbury hospital told us they had not had options for birth discussed with them and were not aware of their birth plans. Another woman who was 36 weeks pregnant said "I had some information when I first went to my doctor but nothing since".
- On Kennington Ward (Gynaecology) patients told us how impressed they were with the ward and how efficient it was and how well staff explained everything to them.
- However a small minority of women told us that they didn't always feel listened to and that staff were "Dismissive" of their concerns.
- We noted that a number of incident reports over the past year documented issues with communication. We noted that ineffective involvement of patients in treatment and decisions was raised as a concern in the February CCG report into the maternity services at the Trust.

Emotional support

- Women could receive emotional support from various sources during their stay in the hospital.
- There were specialist nurses available to offer support and advice for both normal pregnancy and birth and when additional support was required, for example; genetic counselling and bereavement.
- The bereavement lead midwife offered support to women and their families who had suffered bereavement at any time during pregnancy. The bereavement lead midwife linked in with the fetal medicine unit and was able to offer support and counselling to women following discharge from hospital services. We were told that the service was flexible and operated according to the needs and wishes of the patients.
- At the Buckland Hospital emotional support was offered by a dedicated counsellor for maternity and gynaecology services. A specific room was available where women could speak to the counsellor in private.
- We were told that frank and balanced discussions took place between the consultant, the women and their partner regarding options once abnormality detected. Women were given time to come to decision and if requested further discussions about results and counselling for inheritance studies was undertaken by the fetal medicine midwife. Any concerns about blood tests would result in a referral to geneticist and support offered.
- Some of the women we spoke attending the antenatal clinics told us that appointments could be rushed and tended to be focused on practical issues with little time given to discuss feelings.

Are maternity and gynaecology services responsive?

Requires improvement

We found that some of the responsive aspects of the maternity and gynaecology care provided at the William Harvey Hospital required improvement.

At the previous inspection we found there was a lack of capacity with the maternity units across the Trust closing on many occasion. There had been no change in this situation with over 88 closures or diverts happening in the past year. This reduced the choice available and meant that women in labour had to travel more than 30 miles to the next available hospital

There also remained a problem with the lack of capacity in the main x-ray department which meant that ultrasound scans were often delayed. This meant that women sometimes missed 12 and 20 week ultra sound and anomaly scan dates and were at risk from undiagnosed fetal anomalies.

We saw there was limited obstetric theatre capacity at the William Harvey Hospital with only one theatre available for

both emergency and elective surgical interventions. This meant that if a patient required emergency obstetric surgery, elective patients were delayed. A lack of theatre capacity also impacted on the gynaecology services with women having to wait some time for gynaecological procedures, Women sometimes waited all day for their operation and then told to return the following day as other surgical procedures took priority.

We found that delays in discharge were common across both obstetrics and gynaecology wards because of waiting for medication and medical staff to review the women before discharge and the volume of paperwork to be completed. The lack of administrative support compounded the problem at weekends with midwives undertaking all of the discharge paper work including the manual recording of new born babies NHS number.

We found that there remained issues with the general environment across the obstetric department. The temperature on Folkestone ward and in the labour ward was uncomfortably hot. The air-conditioning units had not worked for many months and both patients and staff were suffering in the heat. The bereavement suite was clinical in nature and not appropriate for women and their partners who had suffered the loss of a baby. Facilities for the women's partners were poorly organised. Little consideration had been given of supporting them through the women's stay in hospital.

The complaints system had been reviewed and the senior nursing and midwifery staff were now involved in addressing complaints and concerns and feeding back any issues to staff supported by the governance framework. Gynaecology complaints centred on the area where patients sat prior to going to theatre. Patients who had their surgery in the outside 'Pod' had to wait in the reception area of the ward where there was little privacy or dignity.

The trust covered a large geographical area and maternity services had been arranged to provide ante and post natal care as close to the women's home as possible. There were effective pathways of maternity care across the county. Women were able to access prompt antenatal care and there were systems in place for routine antenatal screening. There were pool facilities for women in labour both in the hospital and for women at home. This meant that women had the choice for a water birth no matter where they chose to have their baby. There was good communication between the hospitals and the community with the community liaison officers coordinating the care of women and their babies.

There were arrangements in place to assist pregnant women with specialised needs, with specialist midwives available to support women in hard to reach groups.

Service planning and delivery to meet the needs of local people

- The trust covered a large geographical area and maternity services had been arranged to provide ante and post natal care as close to the women's home as possible. Clinics took place in hospital settings but also in community settings such as GP surgeries and children's centres. The community midwives also offered a home birth service.
- Women were told they had a choice of giving birth in a midwife-led unit, a consultant led hospital birth, or a home birth. However in reality the choice was limited by geographical location, capacity of the maternity unit and the fitness of the mother and baby.
- Although the majority of obstetric interactions took place in the community we were told there was little cohesion across the county. The new community matron was working with midwives and local stakeholders to benchmark clinics, the on calls and care packages to ensure the same package of care was offered across the county to provide equity.
- The trust met formally with the commissioners, in order to inform the planning and delivery of local services. However concerns had been raised by commissioners that changes in the community midwifery provision had reduced the midwifery cover in parts of the county. One GP practice had raised concerns that they had received no official notification of the changes. The issue was raised at the EKHUFT Contractual Performance Meeting in January 2015.
- There was not a gynaecology assessment service provided at the William Harvey Hospital. Gynaecology emergency patients that attended the emergency department were triaged by the emergency team with support from the gynaecology clinicians. The aim was to respond within 30 minutes. Women who attended the emergency department with blood loss in early pregnancy were seen by the gynaecology team and then referred to the early pregnancy service the following

day. The patient remained in the A&E until they were either admitted or discharged. The hospital had plans to implement a gynaecology assessment service which would accept direct referrals of gynaecology patients.
- Early pregnancy units and day surgery for gynaecology patients were provided on three sites; at the Kent and Canterbury Hospital, the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital. This meant that there was reasonable access across the county for women with gynaecology problems in early pregnancy.
- Inpatient acute gynae-oncology services were currently centralised at the Queen Elizabeth the Queen Mother Hospital for the whole of East Kent.

Access and flow

- We saw evidence of effective pathways of maternity care across the county. Women were able to access prompt antenatal care and the majority of women were booked before 12 weeks and six days and therefore received first trimester screening.
- There were systems in place for routine antenatal screening was in place which was managed by screening coordinators. We saw from the booking diary that approximately 40 women a day were seen in the day care unit at the William Harvey Hospital.
- The hospital offered a limited service for early pregnancy assessment, which was staffed by one nurse per shift. This meant that the nurse covered clerical and receptionist duties alongside of undertaking a limited scanning service and general assessments. Women phoned for an appointment or accessed the unit via the emergency department out of hours. They sometimes had to wait some time to be seen.
- Women accessed the main x-ray department for routine ultrasound scans and emergency radiological interventions; however staff told us there were capacity issues within the radiology department. There was a shortage of sonographers resulting in delays in ultrasound scanning. This meant that women sometimes missed their 12 and 20 week ultra sound and anomaly scan dates. This could result in a baby with Downs Syndrome or other fetal abnormalities being missed. The ultrasound scans are used as part of the screening process for Downs's syndrome and other fetal abnormalities. Scans can be carried out at other times during the pregnancy are less accurate.
- There was a fetal scanning machine available on the day care unit but this was only used for patients attending the fetal medicine clinic. There was also a shortage of appropriately trained midwives to support the scans undertaken in the over stretched radiology department.
- There were processes for midwives to refer women directly for consultant opinion at all stages of pregnancy and childbirth.
- When a women began labour she contacted the labour wards to let them know. The call was then triaged and the woman given advice about what to do next in accordance with their birth plan.
- Staff told us that the majority of women telephoned the delivery suite direct unless they went to the midwife led unit. Staff in the labour ward told us that there was a need for more robust antenatal triaging as the delivery suite had a tendency to get blocked by women in early labour.
- Midwifery and medical staff raised concerns regarding there being only one obstetric theatre at the William Harvey Hospital. This meant that if a patient required emergency obstetric surgery elective patients were delayed. We were told this was on the divisional risk register.
- On the gynaecology ward staff told us there were limited facilities for women requiring surgery during pregnancy for such procedures as removal of retained products of conception as other surgical procedures took priority. Staff told us that "It's a nightmare – women are usually done at the weekend and added to either the elective or emergency list. They could wait all day to be operated on and it may not happen so they would have to return the following day". This could be quite distressing for women waiting to have surgical management of a miscarriage.
- Kennington Ward (Gynaecology) took outliers from other specialities such as medicine and surgery. We were told that these outliers were usually appropriate patients that the ward staff could appropriately care for. However there had been an incident where a patient was admitted to the ward who needed specialist treatment that the ward could not deliver. An incident form was not completed for this.
- Although Maternity Bed Occupancy did fall in the last quarter of 2014/15 the bed occupancy rate was consistently worse than the England average. This meant that staff were under significantly more pressure when admitting and discharging patients.

- Maternity Units across the trust were closed 88 times over 2014/15. Staff told us the last time this happened at the William Harvey Hospital was in March 2015. The unit was closed for a variety of reasons including the labour wards being full, the neonatal intensive care and special care baby units being full and insufficient staff available. This reduced the choice available and meant that women in labour had to travel more than 30 miles to the next available hospital. During peak traffic times this could add a considerable amount of time to their journey to hospital.
- Staff told us that delays in discharge were common. This usually happened because of waiting for medication and the volume of work. Midwives told us that medical reviews took a long time because there were often not enough doctors available. During the week there was a discharge clerk on Folkestone Ward who undertook all the discharge administration. However they were often called away to relieve receptionists and was not covered during breaks or annual leave. When this happened and at weekends, when there was no administrative support to facilitate discharges, midwives undertook clerical functions.
- The system for electronically allocating new born babies an NHS number was not functioning and this was being done manually. This resulted in delays and was potentially a risk for babies being discharged without an NHS number and being required to attend clinics following birth. The discharge clerk told us there was currently a back log of 20 baby notes waiting to be made up.
- The community liaison officers for the Trust were situated at the Kent and Canterbury Hospital. This team provided the liaison between the hospital and community midwives regarding all the births at the trust. Care was coordinated in order that women and babies received post natal visits from community midwives after they were discharged home.

Meeting people's individual needs

- At the William Harvey Hospital we found the temperature on Folkestone ward and in the labour ward was uncomfortably hot. During our inspection the temperature on the labour ward was observed to be 33°C. The patients we spoke with who had recently given birth and staff working on the labour ward told us that it was 'overwhelming' and 'very uncomfortable'. One patient told us that her family had brought in portable electric fans as she was so distressed by the heat. She told us the heat was "Intolerable". Staff said "It's not acceptable that women should be in labour in this heat, they run out of energy and get dehydrated quicker". Patient's told us that it was a little better on Folkestone ward "But not much – it's still too hot".
- Staff told us that the air conditioning had broken in the winter and had not been repaired. We were told that issues with the air conditioning had been raised over a year ago and that a person from the facilities department had visited the unit but nothing had happened. We noted that the staff were so concerned that they had recorded the temperature in the labour suite several times a day over a two week period and brought this to the attention of their managers. They told us it was really difficult to concentrate in the heat and that they became tired much quicker. The temperature in the staff office was noted to be 32°C. The temperature was not included on any of the risk registers available for inspection.
- During the inspection we raised our concerns about the excessively high temperature with the Trust. The acting head of midwifery told us that there was not a business case in place to address this. However by the end of the inspection we were given assurance that funding had now been approved and the facilities department were getting quotes to ensure that all rooms in the labour suite would have working air conditioning within a month.
- We found that across the trust the clinical environment for looking after women health did not always meet best practice guidelines but was compromise between the available space and clinical function. For example the delivery rooms on the labour ward were not en-suite which meant that women in labour had to cross the corridor to use communal facilities.
- At our previous inspection we noted that the transfer of women between units was via public corridors impacting on their privacy and dignity; there was no reception on the antenatal day ward, mothers had to knock and wait at the ward office door and the delivery rooms on the labour ward had no en-suite facilities. Mothers had to cross the main corridor to use the toilets and bathrooms. There had been no improvement to these arrangements at this inspection.
- We noted that the day care unit was operating out of cramped conditions. The unit consisted of a small area down the length of a corridor which included a small

seating area used as a waiting room and a number of side rooms. There were two rooms with couches and recliner chairs where up to four patients could be accommodated however this did not afford much privacy or dignity.

- We found the facilities for caring for bereaved women and their partners did not meet best practice recommendations. There was a small room available with en-suite facilities available for in-patients; however this was situated on Folkestone Ward close to the ward baby feeding room where women may be distressed by hearing and seeing women who had recently given birth. The room was clinical in nature and not furnished or used sympathetically. For example a tea making tray was balanced on a cot and the room was used to store equipment when it was not being used. The Department of Health recommends that women and their families should have access to appropriate facilities should they suffer bereavement where they can grieve the loss of their baby at any stage of pregnancy. A woman who has lost her baby should not be accommodated on a ward/bed room where there are new mothers. Outpatient facilities should include quiet spaces for counselling in the event of bad news and the in-patient facilities should be away from the birthing area and include a separate exit from the ward, for use in the event of bereavement. This level of bereavement facility was not available at the William Harvey Hospital.
- We noted there was poor signage at the Kent and Canterbury Hospital. Staff told us this had resulted in women spending a long time walking round hospital asking for directions. When they arrived at the clinic they were tearful and frustrated, worried they were late for their appointment. Staff told us that this issue was raised over 18 months ago.
- We saw that both the midwife led unit and the consultant led unit had rooms with pool facilities for women in labour. There were also portable pools for women to use in their own homes. This meant that women had the choice for a water birth no matter where they chose to have their baby.
- There were no facilities or arrangements in place for partners who often stayed for the duration of the women's stay in hospital. One partner told us that although they were in a side room they had to sit on the bed as there wasn't a chair. He told us that staff had promised a chair or bed but it hadn't arrived. We spoke with the partner of another woman who had not been able to have a wash or shower for several days. They were acting as an interpreter for their partner because of communication difficulties. They told us they lived too far away to go home for a shower and the staff had not been able to help him by providing a single room for his wife or showering facilities.
- There were arrangements in place to assist women with specialised needs such as bariatric equipment for women with a high BMI (Body Mass Index).
- Staff on the midwife led unit told us how they had helped to support women with special needs in labour. They gave examples of patients who had had spinal surgery or were HIV positive who had had successful labours on the ward even if they may have been transferred to the consultant led unit for the birth.
- There were specialist midwives with responsibilities for hard to reach groups and vulnerable women such as those at risk from domestic violence and teenagers. Although there were no formal systems in place to access hard to reach groups, initiatives were starting to take place with midwives using social media and the internet to start dialogue and reach out to these groups.
- The trust had guidelines in place to help care for expectant mothers with mental health problems. A screening tool was used to help identify vulnerable women who may then be referred to local mental health services via the community mental health intake team. Mental health care plans were drawn up with input from the mental health team and shared with all healthcare professionals and a copy placed in the notes held by the patient. Joint visits were undertaken with the midwives and a mental health worker. We were told that midwives were supported with advice and consultation from the mental health team. Should a women's mental health condition deteriorate during pregnancy there were psychiatric pathways to refer to the mental health crisis resolution team.
- Staff told us that translation services were available, although none of the staff we spoke with had accessed them. They told us they usually worked with the family, unless there were known tensions. Using a relative is not good practice, unless the patient specifically requests it, as there are issues of confidentiality. It is not always possible to be certain that the interpretation is correct and unbiased.

- We saw that information leaflets were available in other formats such as Braille, large print or audio and the Trust could provide documents in various languages on request.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected.
- Since the last inspection the Trust had put into place a new complaints policy. They also made it easier for patients and relatives to raise concerns either in person, by phone, by email or in writing.
- The senior nursing staff and managers told us that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings, briefings and the governance feedback bulletin 'Risky Business'. Band 7s now trained to respond to complaints so now more timely completion
- We examples of this in the June copy of 'Risky Business' where two complaints were highlighted together with the learning to be taken forward.
- The staff we spoke with were aware of the trust's complaint policy and how to facilitate patients if they wished to raise a concern or a formal complaint. They told us that they usually received feedback from any complaint they had been involved with. The ward staff told us they rarely received complaints. They told us that feedback was usually positive.
- Patients we spoke with told us they would raise any issues or concerns with the ward staff in the first instance, but they knew there was a formal complaints process available if needed. We spoke with patients who had raised concerns, and they told us they felt listened to and their concerns addressed.
- Analysis of complaint themes over the past year showed that obstetrics and gynaecology received the greatest number of complaints in the specialist services division. Problems with communication, clinical management, Staff attitude and delays in care were the highest recorded complaint themes for obstetrics across all the Trusts sites, with William Harvey Hospital having the highest.
- Staff on Kennington Ward (Gynaecology) told us the majority of complaints they received were about the area where patients sat prior to going to theatre. We were told women either had surgery in the main theatres or in a 'Pod' which was situated in the car park. Those who attended main theatres were able to wait in the main theatre area. However those who attended the 'Pod', waited in the reception are of the ward. This area was open, with little privacy and women were required to wait in in theatre gowns until their operation.

Are maternity and gynaecology services well-led?

Requires improvement

We found some of the well led aspects of the maternity and gynaecology services offered at the William Harvey Hospital required improvement.

Since the last inspection the midwifery service had been through a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. The Trust identified there had been a culture of bullying and harassment within the trust. They told us of the actions and initiatives that were taking place to address these concerns. The lack of leadership, culture of bullying and lack of strategic direction was felt throughout the midwifery team and had impacted on the obstetric service at the William Harvey Hospital. However since April 2015 a number of interim, acting and substantive posts had been filled and although a number of staff remained unhappy, progress was being made to stabilise the midwifery service. These issues had not affected the gynaecology services which had benefited from stable leadership for some time.

There was not a formalised vision and strategy for women's health services and hadn't been for the past two years, although work was starting on developing a common vision and framework for the community midwifery team.

Since the last inspection the governance framework had been revised and a governance lead midwife was in post working full time.

The trust had various means of engaging with patients and their families. These included various surveys, support groups, the Friends and Family Test, inpatient surveys and the 'How Are We Doing?' initiative. The majority of feedback was positive and was reported back to staff, the trust board and commissioners, in order to inform priorities for improvements.

Maternity and gynaecology

The Trust engaged with staff through team meeting, briefings, emails, team building exercises, conferences and a launch of a staff charter to encourage positive work place behaviour. The majority of staff were encouraged by these initiatives and told us the Trust was a good place to work and getting better.

On the midwife led unit staff told us that morale was generally high with good leadership and positive feedback from the Family and Friends test.

Because of the leadership issues in the midwifery services in the past year there had been little focus on innovation and developing practice. However now the senior management team was becoming more settled managers were starting to involving staff in developing the service for the future. The gynaecology ward was opening a gynaecology assessment unit in the beginning of August. This was due to include a 'nurse' scanner' and was planned to improve the patient pathway for women with urgent or emergency gynaecological problems to avoid them having to access the emergency department to access appropriate care.

Vision and strategy for this service

- We spoke with the acting head of midwifery, senior midwives and nurses in the midwifery and gynaecology teams. They told us that there wasn't a formalised vision and strategy for women's health services.
- In the absence of a formal strategy the acting head of midwifery told us that she was working to ensure there were 'the right staff in place across the trust at the right time'. The senior midwives we spoke with were aware of this priority and were working to ensure this was happening.
- We saw from minutes from the community team that work was starting on developing a common vision and framework for the community midwifery team.
- However at the time of the inspection there was no formal vision and strategy for maternity and gynaecology services and had not been for the past two years.
- The lack of leadership and strategic direction was felt throughout the midwifery team. For example front line staff told us they would carry on 'muddling through' until they were told otherwise.
- There was a lack of visibility of the consultant midwives. We spoke with one consultant midwife but did not get clarity on her role or remit.

Governance, risk management and quality measurement

- The acting head of midwifery told us that since the last inspection the governance framework had been strengthened and formalised. There was now a full time maternity governance lead who reported to the specialist services governance framework and through the trusts governance framework to the Board.
- We spoke with the governance lead who told us about the new governance framework and how they were working to embed a robust reporting culture within women's health. It was acknowledged that there was underreporting of incidents and actions were being taken across the Trust to encourage staff to report more non clinical incidents and near miss events.
- The Trust provided detailed information regarding the governance and reporting arrangements in the specialist services division. We saw that there was now a robust reporting system, with final accountability at board level.
- We saw from the minutes of various governance and risk management meetings that a range of patient safety and quality issues across women's health services were reviewed monthly, including clinical effectiveness, reports from other sub committees such as mortality and morbidity meetings, health and safety, audits, quality and performance data, and infection control. Patient experience, training, HR, trends from complaints, patient surveys, risk and governance committee details were also reviewed monthly. We saw that action logs were in place to detail what should be done, by whom, in order to improve the service.

Leadership of service

- Since the last inspection the midwifery service had identified serious issues with leadership and management. Although a new head of midwifery had been appointed, issues had been identified which meant they were currently on extended leave. The acting deputy head of midwifery was now acting as interim head of maternity and gynaecology. The senior midwifery team and clinical director acknowledged that there had been a loss of focus during the period when the head of midwifery was not actively in post.
- Between September 2014 and March 2015 there had been a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. Although

this centred on the William Harvey Hospital, the effects were felt throughout the midwifery service. During this period many midwifery staff had contacted CQC to inform us of the problems with the leadership. We were told of problems with staff attitudes, bullying and behaviours that were dealt with inappropriately.

- During the early part of 2015 a number of band 8 midwives had either left the service or been suspended. However since April 2015 a number of interim, acting and substantive posts had been filled and although a number of staff remained unhappy, progress was being made to stabilise the midwifery service.
- Feedback from staff was that the leadership within the midwifery service was inexperienced. This was acknowledged by the senior managers we spoke with, who told us about the actions they were taking to address this, such as having an experienced head of midwifery from outside the organisation mentoring the acting head of midwifery; ensuring new staff in management positions were undertaking leadership training and putting in place forums where the managers could meet and discuss any issues.
- We spoke with the Clinical Director for Woman's Health who had joint responsibility with the Head of Midwifery for overseeing clinical risk management throughout the maternity service. The clinical director had been in post for over eight years. They were focused on the medical aspect of women's health services and did not appear to undertake an active role in general clinical risk management and leadership of the service.
- The gynaecology services had benefited by having stable leadership for some time although gynaecology services were poorly represented at senior management level. To address this, the ward sister for gynaecology services had been promoted to matron and was now taking forward women's health issues.
- We spoke with the matron for gynaecology services who told us of her vision in taking the gynaecology services forward.
- Staff told us that members of the Trust's senior management team were not visible on the wards. However a member of staff told us they had emailed the new interim chief executive with concerns and was impressed that they had quickly responded. Staff told us their immediate line managers were visible as they were always on the wards and units and were well aware of the stresses and pressures they were under. They told us that their matron was particularly visible and visited the wards and departments daily. However the consultant midwives were not a visible presence and their role was not clearly defined.

Culture within the service

- The Trust had identified there had been a culture of bullying and harassment across the trust. They told us of the actions and initiatives that were taking place to address these concerns. This included team building exercises, improved communication; improved visibility of senior management team, education and development of nurse managers.
- We were told that this bullying culture had been identified within the maternity department however the action to address the issues had been poorly handled resulting in many staff leaving the service, suspended or off sick. This resulted in a lack of leadership within the department for the past six months. From April 2015 the deputy head of midwifery had been appointed to acting head of midwifery, a number of appointments had been made at matron level and the service was recovering from the damaging past few months. We spoke with staff who had experienced bullying in the past. They told us that the manager they reported this to had been supportive, it was handled appropriately and there was no longer a problem.
- We received much feedback from midwifery staff relating to the past and present culture within the service. Staff told us that in general there had been an improvement in the bullying culture as it had been recognised and addressed. One member of staff told us "We are a lot more aware of how we are perceived by each other – it's about respect".
- Positive feedback included telling us that the changes instigated by the interim chief executive were welcome and noticeable. Staff told us that the change in culture was 'seeping through every area of the hospital'. They told us that there was 'positivity in the air which is very exciting' and that 'management' was slowly becoming more visible and approachable to front line staff. They told us they felt more valued as an employee and encouraged to be better. Staff told us that they felt there were now shared goals and although things were far from perfect there was some direction at last.
- However there remained a large body of staff who still felt disaffected and vulnerable. They told us how damaging the past few months had been and they did

not trust the new management structure or feel motivated or involved in the changes that were taking place. Concerns were raised about on-going perceptions of bullying, abrasive management styles and inexperienced staff appointed to senior posts. One member of staff told us that promotion depended upon who you knew and were friendly with. Other members of staff told us that when their ward manager was 'in one of her moods' they were snappy, stressed and took it out on those nearest her.

- We were told there was still a lot of staff off sick within the maternity unit which managers told us was a symptom of the low morale.
- During the past year there had been 55 episodes of stress-related sickness taken by midwives. Staff sickness was above expected levels and had been for over a year. We were told that sickness absence had not always been managed in line with the Trust policy. The total number of individual midwives who were off with stress during the past year was 43.

Public engagement

- The trust had various means of engaging with patients and their families. These included various surveys, such as the Friends and Family Test, inpatient surveys and the 'How Are We Doing?' initiative.
- Feedback and comments from patients were also shared with patients and the public on posters around the hospitals, and in monthly updates available on the trust's website.
- The new 'How Are We Doing?'/Patient Experience survey questionnaires were now in use at all trust locations.
- The results of the surveys, feedback from complaints and the Patient Advice and Liaison Service, as well as patient comments, were reported back to staff, the trust board and commissioners, in order to inform priorities for improvements.
- There was a local maternity services liaison group where patients were asked to share their views or ideas on how to improve the local maternity services locally.
- The hospital held 'Birth after Thought' sessions to debrief women following their birth experience. However the information from these sessions was not collated and disseminated for learning.

Staff engagement

- Following the last inspection the Trust had developed a staff charter from staff feedback on what a good working environment felt like. The aim was to encourage people to become more aware of the way they behave. A 'Respecting each other' campaign was started to encourage staff to sign up to the Staff Charter.
- Senior managers told us that during the past few months there had been a significant amount of support offered to staff once the scale of the leadership problem was realised.
- There were staff notice boards available throughout the maternity and gynaecology departments giving staff information about local and trust wide issues including training, development and team meeting minutes. This included the 'Women's Health' monthly update. However we noted in theatres that some of the information related to 2008 and had not been recently updated.
- We heard that regular staff meeting were held in all the departments however some midwives told us that they were always too busy to attend. We saw that minutes of the meetings were kept and made available to staff who could not attend.
- In the community we heard that team meetings now had a structured agenda and that midwives were encouraged to become 'Leads' in areas that they were passionate about.
- Although there were a lot of staff who remained unhappy following the leadership issues, feedback from staff was generally positive. They told us "I'm happy to work for this Trust" I believe in this Trust" and I would be happy for my family to be treated here".
- At the Buckland Hospital some of the staff we spoke to told us they felt undervalued and wanted to have their voice heard. Many of the staff were frustrated that they had not been consulted in the design and development of the new maternity unit which opened in June 2015. Staff told us how the layout of the new unit was impractical. They gave the examples of the area to store records was too small with no space to sit down, so the filing had to be completed standing up; while the reception area was too large. Staff felt they had not been supported in the move, moving dates had changed and it had been very stressful.
- We were told that staff working in obstetrics and gynaecology across the Trust were wearing an assortment of uniforms. It was raised as an issue affecting building a cohesive team and there was now a concerted effort to involve staff in choosing a new uniform for the division.

- On the midwife led unit staff told us that morale was generally high with good leadership and positive feedback from the Family and Friends test.

Innovation, improvement and sustainability

- The Trust had opened Improvement and Innovation Hubs to give staff the opportunity to learn about and to contribute to the Trust's improvement journey.
- A nurse, midwife and allied health care professionals conference was held to celebrate innovation and best practice.
- However the leadership issues in the midwifery services meant that staff focus for the past year had been on maintaining a safe service and the day to day work, not developing innovative practices.
- However now the senior management team was becoming more settled managers were starting to involving staff in developing the service.
- The community matron told us how midwives were working to engage with younger pregnant women and teenagers through the use of social media. A working party had been set up to look at innovative ways to engage with hard to reach groups.
- The gynaecology ward was opening a gynaecology assessment unit in the beginning of August. This was due to include a 'nurse' scanner' and was planned to improve the patient pathway for women with urgent or emergency gynaecological problems to avoid them having to access the emergency department to access appropriate care.

Services for children and young people

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

Information about the service

WHH has dedicated children's teams staffed by paediatricians and qualified children's nurses. Padua is the children's ward at WHH and provides inpatient children's services when children need to stay in hospital overnight for treatment as well as day assessment areas. WHH has 28 children's inpatient beds for children and young people between the ages of 0 and 16 years. Padua ward provides inpatient children's services and a day assessment area. The ward has no set visiting times and one parent/carer can stay overnight with their child.

The level 3 NICU has seven intensive care cots, three high dependency cots, 14 special care cots, and one isolation cot. It provides intensive care for new born babies from across the region. The ward has no set visiting times and one parent/carer can stay overnight with their child.

A parents/visitors' sitting room is available for parents/carers, as well as accommodation on hospital grounds. Priority for parents' rooms is given to parents whose babies are critically ill. The children and young people's service does not accommodate brothers or sisters for overnight stays.

The WHH children and young people's service has a list of consultants, who work within a wide range of sub-specialties, allowing a comprehensive list of services to be provided; from premature or sick babies to children with life threatening conditions. Types of care provided includes: acute admissions for sick or injured children and adolescents, recovery following emergency surgery, recovery following planned surgery or planned care requiring an overnight stay.

We inspected this core service as part of our comprehensive Wave 2 acute health services inspection programme. During the announced inspection we visited: Padua children's ward; Channel day surgery; outpatient and surgery areas; the neonatal intensive care unit (NICU), and special care baby unit (SCBU). The children's emergency department was inspected as part of our review of urgent and emergency services.

Services for children and young people

Summary of findings

We found the safe and well-led domains required improvement. Information about safety was not always comprehensive. The trust was using the Kent safeguarding children's board (KSCB) safeguarding procedures. These were not trust specific. The trust had not produced an East Kent University NHS Foundation Trust (EKUNFT) children and young people's safeguarding policy.

Padua ward, NICU and SCBU provided safe and comfortable environments for children. However, the waiting area in the WHH fracture clinic was not child friendly. The fracture clinic had a children's bay in the clinic which staff had decorated in child friendly décor. However, there was no designated waiting area for children and their families; waiting room conditions were cramped and overcrowded.

There was an increased risk that people could be harmed, due to medicines not being secure in children's ward areas and adult medicines being placed on top of a children's resuscitation trolley in the outpatients department. On Padua ward medicines fridge temperature had a number of omissions. A number of patient group directions (PGD's) were out of date.

Gap analysis had been conducted to identify staff that needed up-to-date training in children and young people's safeguarding to an appropriate level. The training was being rolled out across the trust.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to people who use services.

Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Padua ward had a practice development nurse who monitored staff practice to ensure consistency.

Children and young people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and service accreditation. The trust had achieved level 1 UNICEF Baby Friendly accreditation for supporting breastfeeding and parent infant relationships by working with public services to improve standards of care.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were supported to deliver effective care and treatment through supervision and appraisal processes.

When people received care from a range of different staff, teams or services, this was coordinated. Staff worked collaboratively to understand and meet the range and complexity of children and young people's needs. Staff could generally access the information they needed to assess, plan and deliver care to people in a timely way.

Consent to care and treatment was obtained in line with legislation and guidance. Children and young people were supported to make decisions. Processes for seeking consent were appropriate.

Feedback from children, young people and families who used the service was mostly positive about the way staff treated people. Children and young people were treated with dignity, respect and kindness during interactions with staff and relationships with staff were positive.

Children, young people and their families were involved and encouraged to be partners in their care and in making decisions, with any support they needed. Staff spent time talking to children, young people and their parents. Parents told us staff worked with them to plan care and share decision-making about care and treatment.

Staff responded compassionately when patient's needed help. Staff took appropriate steps on the ward

Services for children and young people

to ensure patient's privacy and confidentiality was respected. Staff helped children, young people and their families to cope emotionally with their care and treatment.

Children and young people's needs were met through the way services were organised and delivered. The importance of flexibility, choice and continuity of care was reflected in service provision. The needs of different patients were taken into account when planning and delivering care and treatment. Care and treatment was coordinated with other services and other providers.

Children and young people could access the right care at the right time. Access to care was managed to take account of patients' needs, including those with urgent needs. Waiting times, delays and cancellations were minimal and managed appropriately. Services ran on time. Patients were kept informed of any disruption to their care or treatment.

It was easy for people to complain or raise concerns. Complaints and concerns were always taken seriously, responded to in a timely way and listened to. Improvements were made to the quality of care as a result of complaints and concerns.

The values for children and young people's services had been developed with elements such as compassion, dignity and equality. However, there was no long-term vision or strategy in place for children and young people's services. The trust had conducted a recent strategic review of children and young people's services, and concluded that the proposed strategy of children and young people's services operating from one site was not viable. At the time of our inspection there was no decision pending on what the vision or strategy would be for children and young people's services.

The board and other levels of governance within the organization had undergone changes in the past 12 months. The chief nurse and director of quality had been instated as the children and young people's services lead. The service's structures, processes and systems of accountability were set out and understood by staff.

The leadership was knowledgeable about quality issues and understood what the challenges to children and young people's services were.

The Senior Matron for children and young people was based at The William Harvey Hospital. The Matron for children and young people was based at Queen Elizabeth Queen Mother Hospital. They both provided support and cover across all sites.

The culture change programme encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. However, staff reported that ward managers for children and young people's services had been overlooked for administrative support.

There was evidence that the leadership had introduced processes that would actively shape the culture through effective engagement with staff, people who use services and their representatives and stakeholders. Senior leaders encouraged a culture of collective responsibility between teams and services. But, these processes were not embedded.

The children's and young people's service was proactively engaging with and involving all staff to ensure that the voices of staff were heard and acted on. The leadership actively promoted staff empowerment to drive improvement and a culture where the benefit of raising concerns was valued.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We found the safe domain required improvement. Information about safety was not always comprehensive. The trust was using the Kent safeguarding children's board (KSCB) safeguarding procedures. These were not trust specific. The trust had not produced an East Kent NHS trust children and young people's safeguarding policy.

Padua ward, NICU and SCBU provided safe and comfortable environments for children. However, the waiting area in the WHH fracture clinic was not child friendly. The fracture clinic had a children's bay in the clinic which staff had decorated in child friendly décor. However, there was no designated waiting area for children and their families; waiting room conditions were cramped and overcrowded.

Gap analysis had been conducted to identify staff that needed up-to-date training in children and young people's safeguarding to an appropriate level. The training was being rolled out across the trust.

There was an increased risk that people could be harmed, due to medicines not being secure in children's ward areas and adult medicines being placed on top of a children's resuscitation trolley in the outpatients department. On Padua ward medicines fridge temperature had a number of omissions. A number of patient group directions (PGD's) were out of date.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to people who use services.

Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.

Incidents

- All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system.
- The service had systems in place to ensure that incidents were reported and investigated appropriately. The trust informed us that WHH had one serious incident in the previous 12 months. However, this had happened very recently and was under investigation at the time of our visit. We saw that a root cause analysis (RCA) was completed as part of the investigation of incidents. RCAs identified learning from incidents and lessons learned from incidents were shared across teams. An action plan was developed as a result of RCAs. There was a system to investigate the cause of incidents and feedback the findings to the clinical governance meeting.
- The reports from all paediatric incidents within the child health division were reviewed at clinical governance meetings. The trust had a quarterly magazine for staff 'Risk Wise' which examined case studies of adverse incidents. For example, in issue 15, spring 2015, delayed diagnosis in children with meningitis was examined as well as the trust's patient safety strategy. We saw that copies of 'Risk Wise' were available in the William Harvey Hospital (WHH) staff room and staff areas.
- The trust did not have a forum for sharing incidents involving children seen by other divisions other than those which were classified as SI's and reported onto strategic executive information system (STEIS). STEIS is the national reporting system for serious incidents. Where an incident involving a child or young person was reported by another division, it was the responsibility of that division to contact the child health senior matron or specialist services governance team and/or add the senior matron as an additional investigator to the incident. The trust informed us that the issue of other divisions' incidents being reported to children and young people's services had been discussed at the trust's electronic record users forum. As a result the specialist services governance team requested that an automatic notification system be developed to identify all incidents involving under 16 year olds reported by other divisions via a generic email address for the child health governance team. Work was in progress on this.
- Mortality and morbidity meetings were held monthly as part of the children and young people's audit meeting.

All junior doctors, consultants and nursing staff were invited to the meetings. A schedule of cases for each meeting was planned and any actions required were identified and recorded. Learning was shared across the various medical, nursing and other professional scheduled meetings.

Safety Thermometer

- Padua ward and NICU used the NHS adult Safety Thermometer. The NHS Safety Thermometer is a point of care survey instrument that is used to measure progress in providing a care environment free of harm for patients. Staff told us the wards used the adults Safety Thermometer mainly to monitor pressure ulcers as the information the adult instrument provided was limited for children's and young people's services; but, work was underway to introduce the specialist paediatric Safety Thermometer in 2015.
- We viewed the Safety Thermometer results for the past 12 months. We saw that patients on Padua ward had been provided with 100% harm free environments in the 12 month preceding our inspection. NICU had been 100% harm free since February 2015.

Cleanliness, infection control and hygiene

- A private company was contracted to provide cleaning services across the trust. All the WHH areas we visited were clean. We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- Monthly infection control audits were undertaken by the matron. The Padua ward infection control link nurse undertook weekly infection control audits of hand washing technique, commodes and mattresses. For the year to date, children and young people's services were meeting NICE standards for infection control. We also saw there were effective arrangements in place for the storage, handling, and disposal of clinical waste.
- We saw that checklists were used to verify that designated cleaning tasks had been completed. At the time of our visit, children's and young people's services were achieving trust standards for hand hygiene. The service was also achieving 100% compliance with the national institute for clinical excellence (NICE) national specifications for cleaning. We saw that gloves, aprons, and other personal protective equipment (PPE) were readily available and used by staff.
- Hand washing facilities and hand sanitising gels were readily available. 'Bare below the elbow' policies were adhered to. The importance of all visitors cleaning their hands was publicised and we observed parents and other visitors using hand gels and washing their hands.
- The Padua ward areas had an ample supply of appropriate toys that could be cleaned safely. Play specialist staff told us that toys in the children's ward were cleaned by them as part of their role. We viewed the schedules for toy cleaning on Padua ward and saw these were up to date.
- There had been no reported cases of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C. diff) for children's and young people's services in the past 12 months.
- A programme of training was in place for 'aseptic no touch technique' (ANTT). There were suitable arrangements in place to support staff with infection control issues. An infection control link nurse provided support to staff on Padua ward.

Environment and equipment

- Padua ward, NICU, and SCBU provided care in safe and suitable environments. Environmental risk assessments had been undertaken. The children and young people's ward areas provided a safe environment for children and families in terms of cleaning and maintenance. Staff had access to age appropriate recovery equipment for children following surgery.
- Entrances to all children's ward areas were secure, entry was granted by a member of staff via an intercom for visitors during the day and at night. On Padua ward access was granted by a ward clerk at reception during the day and by ward staff at night.
- The outpatients department had a new purpose built child friendly waiting area. Staff told us the waiting area was waiting for new toys to be delivered. This meant children and young people would have an appropriate environment to wait for their outpatients appointments.
- The waiting area in the fracture clinic was not child friendly. The fracture clinic had a children's bay in the clinic which staff had decorated in child friendly décor. However, there was no designated waiting area for children and their families. When we visited the waiting room conditions were cramped and overcrowded. Staff

told us there were plans in place for the fracture clinic to move into new premises but a date had not been set for this. Staff told us they didn't think this would happen within the next 12 months.

- The matron told us the provision of specialist paediatric equipment had been standardised across the trust. The trust's risk register's recorded that all equipment in children and young people's services across the trust had been standardised, with the exception of the multi–parameter monitors, which could pose a potential risk as staff worked across children and young people's services at the trust. The matron told us to mitigate this risk staff were required to maintain equipment competencies on all equipment yearly.
- The equipment used to look after children on the day surgical ward was safe. For example, pumps were available for children and young people to receive intravenous (IV) fluids to ensure the correct amount of fluid was given at the correct rate.
- Piped oxygen and suction was available in some areas where children were treated. We saw that this equipment was fit for purpose and readily to hand. Paediatric resuscitation equipment was available in areas where children were treated.
- All the staff we spoke with reported adequate access to equipment. We viewed records that equipment was checked on a weekly basis and further checks were in place on the special care baby unit (SCBU).
- Age-appropriate resuscitation and emergency equipment was available for staff across children's and young people's services. Daily safety check protocols for emergency equipment were in place and up to date. We saw that age-appropriate resuscitation equipment had been introduced in the outpatients department.

Medicines

- We noted on Padua ward that the medicines fridge temperature had not been recorded from 19 May 2015 to 27 May 205; there were also omissions of temperature recording on the 3 June 2015.
- Access to medicines and drugs was not secure in the special care baby unit (SCBU). For example, we saw cupboards where drugs were kept, left open, and the door to the room was also open. This meant unauthorised people could have accessed drug cupboards. We also noted that the medicines cupboard on the assessment bay on Padua ward was unlocked.
- In the outpatients department we saw adult medicines being stored in an accessible container on top on the children and young people's resuscitation trolley. We discussed this with the outpatients ward manager who said they shouldn't have been there. We returned the next day and saw that the container had been removed from the resuscitation trolley and clear signage had been introduced by the outpatients ward manager to indicate that the trolley was to be used for children only.
- We noted that the children and young people's service had patient group directions (PGD) in place. In practice this means that a PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. Some of the nursing staff were authorised to administer medicines under a PGD. We noted that many of the PGD's had expired in 2014 and had not been reviewed and updated. For example, the PGD for cyclizine, a medicine to control nausea and vomiting, had an expiry date of November 2014.
- Up to date copies of the British National Formulary for Children were not available on all wards and departments. There was an up to date copy in the ward manager's office on Padua ward.
- A separate supply service was provided by pharmacist technicians and we saw evidence of the weekly checks on safe storage which were carried out in addition to the 6 monthly hospital wide audits. We noted two open medicine cupboards were observed which could be accessed unlawfully and fridge temperatures were not always recorded daily to ensure that the potency of medicines requiring cold storage was maintained. There was a separate fridge to store chemotherapy and action was taken on the day of the inspection to replace an expired extravasation kit used to treat a possible side effect when administering chemotherapy. We were told later that an immediate monitoring service had been implemented throughout the trust to prevent this happening again.

- Outpatient prescriptions for use by consultants were kept securely and their supply robustly controlled.
- We viewed seven children and young people's medicines records. The trust did not use a dedicated paediatric medicines chart. Children and young people's allergies were clearly documented on their medicines administration records. Children and young people's PEWS score was recorded, together with their pain score and any medicines prescribed to manage pain. Children's weight was clearly documented and prescriptions were appropriate for children's weight.
- The trust had a paediatric lead pharmacist, band 8A, for children and young people's services that staff could liaise with and ask for advice. The pharmacist worked across all the children and young people's ward and department areas. The pharmacist attended the children's wards and NICU daily, reviewing prescriptions and making recommendations. Out of hours, the hospital had an on-call pharmacist. Staff we spoke with said the on-call pharmacist was accessible.
- All medication errors were reported as incidents, recorded on the electronic system, investigated and reviewed at the monthly governance and quality group. Staff were open and reported medication incidents. We saw evidence that these were investigated, and staff involved in incidents were seen on an individual basis, during which they were asked to write a reflective review on the incident. Where the incident was a prescribing error, senior medical staff were informed and the error was followed up with the doctor concerned.
- Some of the staff we spoke with told us there was sometimes a delay in receiving discharge medicines from pharmacy, but that Padua ward kept labelled prepacks for some frequently prescribed children's medicines to try to minimise any delays.
- Across the children and young people's wards we found that access to controlled drugs (CD's) was restricted to appropriate designated staff and CD's were secured inside a double locked cupboard. A CD register was in place. This is a bonded book used to record CD medicines. We found no discrepancies between the stock, controlled drugs in the cupboard, and the CD register.
- The pharmacist undertook regular medicines audits the most recent of these had been in January 2015.
- A band 5 nurse we spoke to told us they had read the trusts medicines policies, observed practice, and learnt about children's doses of medicines during their induction. The nurse told us they had their medicines competency assessed; and always had a complicated drugs calculation checked by a senior member of staff. The nurse was aware of how to report medicines errors and how to obtain pharmacist advice on medicines out of hours.

Records

- We viewed the July 2015 staff training record for children and young people's services. We saw that 51% of medical and dental staff had completed mandatory training in information governance. 75% of staff on the NICU were up to date with mandatory information governance training and 67% of staff on Padua ward up to date with mandatory training in information governance. This meant some staff did not have up to date training in the trust's recording processes and practices.
- We viewed seven children and young people's medical and nursing records. We found these were appropriately completed with dates and times recorded.
- Records documented that appropriate safeguarding procedures had been followed and appropriate referrals to other services such as mental health teams and social services were timely.
- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept on the wards in trolleys and kept around a corner by the nurses' station. However, on Padua ward we found the trolley was unlocked and this posed the risk of unauthorised access to patient information.
- Patients were identified on whiteboards on the wall opposite the nurses' station on Padua ward. However, this was visible to people visiting the ward and could have compromised patient confidentiality.
- We looked at seven sets of notes on the wards, the neo-natal unit, and SCBU; we found them to be accurate and legible. We found both medical and nursing records were appropriately completed with dates and times recorded. Patient Information was easy to find.
- Documentation for admitting patients and assessing needs and risks was child-centred.

- We unable to view staff training records as these were not available. We were unable to establish whether most staff training in information governance was up to date.
- Leaflets explaining patients' rights to access their medical records were available on the ward. The trust's website carried information on people's rights under the Freedom of Information Act 2000.
- The care pathway records used for children's surgery documented the child's care and treatment from pre-assessment, surgery, recovery and through to discharge. The documentation used included nationally recognised surgical safety checklists and prompts for staff to ensure multidisciplinary working between nursing and medical staff, as well as information sharing with children, young people and parents.
- We saw that the documentation used in the Channel day surgery unit was the same as that used on the children's ward. The paediatric procedure pathway included a pain tool that was child friendly.
- On the NICU, specific neonatal care plans were used to ensure that the care babies received was consistent with neonatal best practice.
- We viewed the trust's audit report for March 2015 and saw that an audit of note keeping in paediatric therapies was scheduled to be included on the 2015-16 audit plan.

Safeguarding

- Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns. The WHH staff training record for July 2015 recorded that a total of 91% of staff on NICU and 92% of staff on Padua ward were up to date with mandatory safeguarding training updates.
- The children's safeguarding meeting minutes 1 July 2015 recorded that all children's safeguarding policies and procedures had been reviewed and updated. The trust was using the Kent and Medway procedures for safeguarding. The trust informed us that the Kent and Medway procedures had been created following extensive collaboration with all partner agencies, and the trust had participated fully in their compilation and updating. We saw that these were available on the trust's intranet, and were based on best practice and local safeguarding protocols. However, the trust did not have a safeguarding policy that was specific to the trust and provided trust specific guidance for staff working at WHH or across the trust. This meant staff would not have access to a children and young people's safeguarding policy that was specific to the trust.
- The trust employed children's safeguarding lead nurses who worked with wards and departments, raising awareness and offering support, advice and resources where necessary. Each safeguarding lead nurse worked collaboratively with other health and social care organisations.
- We spoke with the trust's safeguarding lead nurse who told us work was in progress in training all staff to an appropriate level as set out in the intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff, 2014'. The trust had an action plan in place to ensure compliance with the intercollegiate guidance. We viewed minutes from the trust's children's safeguarding meeting dated 1 July 2015. These recorded that the trust was in the process of conducting a gap analysis to ensure that staff across the trust received safeguarding training to the appropriate level for their role. The target date for the completion of training was the end of the year. The safeguarding lead told us the gap analysis figures were fed back monthly to the trust's board.
- The trust's safeguarding lead told us the trust's safeguarding training and practice was based upon the Kent Safeguarding Children's Board (KSCB) policies and procedures. This included recommendations from 'Working together to safeguard children, 2015'. The safeguarding lead nurse told us they were a member of the KSCB learning and development group.
- The trust had recently identified a named consultant for children's safeguarding. The trust's children's safeguarding lead was a qualified midwife and registered nurse. There were also named children's safeguarding leads at all the trust's hospital sites. Staff we spoke with told us they would liaise with the safeguarding lead if they had safeguarding concerns. Staff on the wards had access to the contact details of the local authority safeguarding team for out of hours safeguarding advice or to report concerns. The trust had information sharing protocols in place with the local authority.

- The safeguarding lead told us children who were known to have safeguarding concerns would be flagged on the patient admissions system (PAS) to alert all staff who came into contact with the child.
- The trust was in the process of rolling out training to safeguard women or children with, or at risk of, female genital mutilation (FGM) and trafficking as part of the trust's child sexual exploitation training. Child sexual exploitation was a standard agenda item at the trust's children's safeguarding meetings. However, the trust did not have specific guidance available to staff on FGM, and were relying on staff accessing information from the Kent and Medway safeguarding children's board website.
- Access to children's wards had key codes on all access doors. We saw the receptionist on Padua ward asking visitors the name of the patient they were visiting. This meant the wards were taking action to minimise the risk of abduction to children and young people.

Mandatory training

- Staff we spoke with confirmed that they were up to date with mandatory training. Mandatory training included: fire safety; moving and handling; health and safety; information governance; infection prevention and control; equality and diversity; and safeguarding children and young people.
- We viewed the July 2015 staff training spread sheet for children and young people's services. This indicated that across women and children's services there were a number of medical and dental staff that had not completed the required mandatory training updates. The nursing staff on Padua ward had between 92% and 100% compliance with mandatory training. The NICU had 100% compliance with most mandatory training, with the exception of children's safeguarding which was 88%.
- The staff room displayed information about training for staff. For example, we saw posters informing staff of dates for level three safeguarding training updates displayed in staff areas.
- Staff we spoke with confirmed they had received an annual appraisal in the past 12 months. The trust's balanced scorecard indicated that across children and young people's services over 90% of staff had received an up to date appraisal.

Assessing and responding to patient risk

- Staff told us the trust was rolling out new assessment and care planning documentation in 2015. The trust's child health briefing document June 2015 noted that there had been a delay in making amendments to the new assessment and inpatient documentation. Staff told us the roll out of the new assessment materials would commence once the multi-functional machines had been received on the wards. Introduction of the new assessment documentation would be staggered to facilitate staff in transitioning from the current system.
- There were two paediatric medical high dependency unit (HDU) beds on Padua. The matron told us the level of the care provided could flex up or down from level 2 to level 3. The matron told us there had not been any incidents on the HDU. The RCPCH report, 'High dependency care for children: Time to move on', 2014, recommends that a level 2 unit should have a minimum of one nurse on every shift, who is directly involved with caring for a critically ill child, who has successfully completed a validated/accredited education and training programme of study addressing all the required skills to level 2. The trust was meeting this standard. The matron told us the trust were in discussions with a local university to provide HDU training as the trust had cancelled its in-house training course and intended to outsource this.
- A policy was in place for the management of children requiring HDU care and the transfer of a critically ill child whose care could not be managed at WH hospital to a tertiary centre, (tertiary centres are large hospitals providing specialist care). In the case of an urgent transfer the North Thames children's acute transport service or the South Thames retrieval service (STRS) would be asked to provide urgent transport, this included access to an air ambulance service.

- Some staff told us that there had been delays with the transport provider for non-urgent transfers. However, staff told us the trust was reviewing its contract with this provider. Staff told us delays in transport provision would be recorded as an incident.
- The service used a paediatric early warning score (PEWS) system on the children's wards, NICU used neonatal PEWS, these charts were based on the NHS institute for innovation and improvement PEWS system. This tool supported early identification of children at risk of deterioration. There were clear directions for escalation within each child's file on the wards. We spoke with staff, who were aware of the appropriate action to be taken if patients scored higher than expected. We reviewed notes and saw that where higher scores had been recorded, action had been taken to escalate concerns, or the rationale for not escalating had been documented. On NICU neonatal PEWS charts were used.
- In case of an emergency within the children and young people's inpatient area all band 6 and band 5 nurses on Padua ward were trained in paediatric life support (PILS). The Padua ward manager was a trainer, and some band 6 nurses were trained in advanced paediatric life support, (APLS). The matron informed us that six further nursing staff would receive this training in October 2015. All qualified staff on the NICU had received new born life support (NBLS) training.
- Children who had undergone surgical procedures were transferred to Padua children's ward at the earliest opportunity.

Nursing staffing

- A royal college of paediatrics and child health (RCPCH) service review was commissioned by the trust and published in 2015. The review reported that a trust wide review in 2014 had resulted in increased nursing staffing levels to ensure nursing levels were meeting the RCN 2013 one to four ratio during the day.
- At the time of our visit staffing levels were adequate, as was the required skill mix. Staffing levels conformed to the Royal College of Nursing (RCN) guidance 'defining staffing levels for children and young people's services' 2013. There was a minimum of two registered children's nurses at all times in all children and young people's inpatient and day care areas. We viewed staffing rotas for the previous month that confirmed this.
- Staff we spoke with reported that there was sufficient nursing staff to ensure that shifts were filled in line with their agreed staffing numbers. Padua ward had developed a Facebook page where unfilled shifts were advertised to Padua ward staff. Staff could offer to work extra shifts via Facebook.
- The matron informed us that as a result of the RCPCH report a band 6 nurse was on duty at all times during day and night shifts. If more senior advice was needed the ward staff could contact the ward manager or the matron.
- There were no advanced neonatal nurse practitioners (ANNP) employed by the trust. NICU had a research nurse and special care co-ordinator. There were no specialist surgical nurses on NICU. Surgical services were supported by the Evelina children's hospital in London. The trust was looking to employ advanced neonatal nurse practitioners (ANNPs). These are very experienced nurses with additional training which enabled them to work autonomously to the equivalent of up to a registrar level doctor. However, they were not advertising this position at the time of our visit.
- The usual NICU staffing level was five or six qualified in speciality (QIS) nurses on each shift.
- The trust informed us that temporary staff must have relevant and appropriate training and experience and provide evidence of being a registered paediatric nurse (RN60) or a registered nurse who was adult trained but had paediatric experience (RN00). The trust added that nurses without the relevant training would not be employed. The trust kept records of temporary staff inductions.
- The RCPCH reported that advanced paediatric nurse practitioner were being developed (APNPs) with 2.7 whole time equivalent (WTE) posts at WHH. The trust had employed a practice development nurse to support newly qualified band 5 nurses and support nursing staff training.

- RCPCH reported that NICU had been reviewed in 2015 using the Department of Health (DoH) neonatal toolkit calculator. Nurse to infant ratios met the British Association of Perinatal Medicine (BAPM) guidelines.
- The trust used the 'Health Roster' tool to estimate the number of nursing staff and skill mix required to maintain safe staffing numbers on wards. Activity based on the age of the children was reviewed daily by the ward managers to ensure compliance with the RCN guidance on staffing. RAG, (red, amber, green) ratings were used to assess safe staffing levels. The RAG ratings indicated that overall staffing levels across children and young people's services were generally appropriate across all shifts. There were five to six nurses on the roster per shift, and one health care assistant (HCA) to support both clinical and non-clinical work.
- The trust had an escalation of staffing concerns policy. Staff told us staffing red flag events were closely monitored and were monitored and reported through the clinical incidents and complaints process.
- Nursing staff on Padua ward told us they had a twice daily hand over; staff were not to be disturbed during hand overs as this was protected time. Nursing handovers occurred at each change of shift. We observed a handover on Padua ward. The nurse in charge who had the overall co-ordinating role, received a detailed handover from their counterpart. We viewed a Padua ward handover sheet and saw that staffing for the shift was discussed, as well as any high risk patients or potential issues.
- We viewed the children and young people's child health dashboard. This recorded that the service was achieving 96% of rostered staffing levels across the trust.

Medical staffing

- All children were seen by a consultant within 24 hours of admission to the ward.
- The trust's medical staffing skill mix was 30% consultants; this was 4% below the national average. However, this was mitigated by the trust's senior house officers, doctors with at least three years or more experience in children and young people's services, making up 21% of medical staffing, this was 14% above the national average. 43% of medical staff were registrar level, this compared with a national average of 51%. 5% of the medical staffing mix were junior doctors, completing foundation year one or two. This was slightly lower than the national average of 7%.
- WHH medical staffing consisted of five consultant paediatricians, plus two who worked in the community. There was also an out of hours rota. The trust was meeting BAPM 2014 guidelines for medical staffing on NICU. There were four consultant neonatologists and two paediatricians with neonatal interest. There was a one in six on-call rota for NICU, with a consultant of the week system that operated bi-weekly. Weekend on-call cover was from 3pm on Friday to handover on Monday morning.
- The trust had a 2nd tier rota that covered both the paediatric ward and NICU. The trust had recently recruited two speciality doctors, meaning there would be seven full-time paediatric speciality doctors employed in paediatric services at WHH. Junior doctors across children and young people's services reported that they had very good training and support from their senior consultants. Consultants told us they did not have issues recruiting to consultant posts.
- WHH had two deanery middle grade doctors working in the paediatric wards during the day and two middle grade doctors who worked on NICU
- There were separate rotas for tier one, with one trained in speciality doctor, seven G.P trainees, and a foundation year doctor for paediatrics. NICU had seven deanery trainees.
- Middle grade doctors on the on-call rota and at night provided cover for both acute paediatrics, paediatric needs in the A&E, and the NICU. Following a 2015 review by RCPCH two middle grade doctors from QEQM hospital had been reassigned to WHH.
- Medical staff told us a business case had been forwarded to the board for extended working for consultants. This would extend consultant hours from the current 5.00pm finish time to 9.00pm, in line with RCPCH 'Facing the Future' standards.
- Consultants undertook ward rounds daily, including at weekends. A neonatal consultant was on-call at all

times and none of the staff reported any difficulties or delays in receiving attention from a consultant. Nurses told us that when they were concerned about a patient, they were encouraged to call the consultant.

- There were three handover sessions per day for the medical teams. A consultant was present at the 8.30am and 4.30pm handovers. The third handover at 8.30pm was led by a middle grade doctor. A community speciality doctor was also used on the WHH on-call rota.

Major incident awareness and training

- Staff were aware of the trust's major incident and business continuity policy; senior staff understood their roles and responsibilities within a major incident. Staff told us they had not been involved in a rehearsal for a major incident. However, the trust had produced a major incident training video which staff were required to watch.
- The trust had an escalation policy for dealing with surges in demand on children and young people's services. The policy was RAG rated and had an action plan to provide guidance for staff at each stage. The policy also had a black rating, this included times when the trust's children's and young people's hospitals would need to be closed to new admissions due to bed occupancy being at 100%.
- The ward manager on Padua ward told us the trust's escalation policy would be used at times of inclement weather, this included arrangements for staff that were stranded at work to stay on the premises and provide cover for staff who could not get in to work.

Are services for children and young people effective?

Good

Children and young people had good outcomes because they received effective care and treatment that met their needs. Padua ward had a practice development nurse who monitored staff practice to ensure consistency.

Children and young people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and service accreditation. The trust had achieved level 1 UNICEF Baby Friendly accreditation for supporting breastfeeding and parent infant relationships by working with public services to improve standards of care.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were supported to deliver effective care and treatment through supervision and appraisal processes..

When children and young people were due to move between services their needs were assessed early, with the involvement of all necessary staff, teams and services; discharge and transition plans took account of patients individual needs, circumstances, on-going care arrangements and expected outcomes.

Consent to care and treatment was obtained in line with legislation and guidance. Children and young people were supported to make decisions. Processes for seeking consent were appropriate.

Evidence-based care and treatment

- Children and young people's services had a band 7 nurse clinical practice development nurse who was responsible for aligning nursing practice to national best practice guidance.
- NICU commenced the BLISS baby charter audit in June 2015. The audit is a practical guide to help hospitals provide the best possible family-centred care for premature and sick babies. The audit tool allows hospitals to assess the quality of the family-centred care they provide against the BLISS charter's seven principles of care.
- The trust had achieved level 1 UNICEF Baby Friendly accreditation. The trust was working towards level 2. The Baby Friendly Initiative is based on a UNICEF and the World Health Organization (WHO) global

accreditation programme. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.

- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH). We saw appropriate care pathways were in use and were in keeping with the relevant clinical or nursing guidance. For example, Channel day surgery had produced a care pathway for patients who were assessed as suitable for day surgery, the pathway included prompts for staff to ensure they had completed pre-operative checks.
- Policies, procedures and guidelines were available to all staff, including temporary staff, via the trust intranet. However, some staff we spoke to said there was sometimes difficulties accessing them when necessary due glitches with to the trust's electronic system, 'Share Point'. Staff told us the 'Share point' system was sometimes slow and unreliable. Staff informed us that the IT department had been informed.
- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH). We saw appropriate care pathways were in use and were in keeping with the relevant clinical or nursing guidance. For example, we viewed the care pathway for fast-tracking an acutely unwell child aged under one year from the accident and emergency (A&E) department to the paediatric teams and wards. This meant that a child could receive rapid intervention from the specialist paediatric team. The trust had a range of guidelines available to guide staff when providing care and treatment. We also viewed 'the guidelines for acute asthma in children'; these had been ratified by the trust's paediatric clinical governance team in February 2014 and were due to be reviewed in February 2016.
- We viewed the trust's clinical audit progress report, March 2015; this outlined the progress of the trust's program of audits at a particular point in the year. Staff told us that a meeting had been planned to review and monitor the progress of clinical audits on the 30 June 2015. Records we viewed confirmed this. The service was involved in a range of local and national audits. For example, we viewed the children and young people's audit planner for 2015-16. Work was in progress to audit the service's implementation of a range of national audits, including: national diabetes audit, which was having data collected at the time of our visit; and the national paediatric asthma audit, which was due to commence data collection in November 2015. We saw that work was also in progress on a range of local audits. These included an audit of 'initial health assessments for looked after children'. This audit was having information processed at the time of our visit and results were unavailable.

Pain relief

- Pain was assessed and managed appropriately. We observed age-specific tools in use in the children's assessment unit (CAU) and the appropriate national guidance was followed.
- Staff told us patients were given analgesia, as required, and staff monitored whether the analgesia had adequately relieved the child's pain. We did not see any patients being administered pain relief during our inspection.
- Appropriate equipment was available including equipment for patient-controlled analgesia (PCA).
- A nationally recognised pain management tool was used as part of children and young people's assessment. Pain scores were recorded on patient's PEWS charts.
- A parent we spoke with confirmed that staff had ensured their child was not in pain following a tonsillectomy procedure.
- We saw a consultant discussing pain relief with the parent's of a child during a ward round on Padua ward. The child's parents were fully involved in the conversation and asked for their views.

Nutrition and hydration

- The ward areas had a protected mealtime's policy, which meant that children and young people could eat without being disturbed, except for parents and siblings. We saw that this was observed by staff on the ward.
- Padua ward had introduced a screening tool for the assessment of malnutrition in paediatrics (STAMP), a validated nutrition screening tool for use in hospitalised

children aged between two and 16 years, to ensure children at risk of being obese or malnourished were identified. Staff told us every child over the age of two years had their nutrition and hydration needs reviewed every night.

- We noted that there were plans of care for any children at risk, with input from speciality teams as required. Children and babies were frequently weighed, and there were records relating to their fluid, nutritional intake and output being monitored.
- Support was available from dieticians for specialist advice and support with special diets and feeds. The staff were also aware of how to order specialist menu choices, such as halal food or gluten-free meals.
- There were adequate facilities for the management of bottle-feeding.

Patient outcomes

- We viewed the children and young people's audit planner. We saw the service had plans in place to ensure they took part in national clinical audits. Audits that were not in progress had commencement dates This ensured that the trust had a framework of action in place; including the review of all clinical guidance and the undertaking of gap analyses to ensure all specialist services who provide care for children had a detailed clinical audit programme in place for 2015/16. The service also had a programme of audits that would be undertaken at a local level across children's services to monitor the quality of care provided to children and young people. However, we did not see evidence of how audit results had been fed back to staff to ensure that the results could be used to improve service delivery, this was due to audits either being in progress or awaiting commencement.
- The trust takes part in the national neonatal audit (NNAP) in 2013. The most recent NNAP report showed that, for the period of January to December 2013. The trust achieved the standards: that (86% against a target of 100%) of babies of less than 28 weeks gestation had their temperature taken within one hour of delivery: mothers of premature babies received antenatal steroids (93% against a target of 85%): babies that received mother's milk when discharged from a neonatal unit (38% against the national average from this audit of 50%) other key standards were babies that received retinopathy of prematurity screening (89% against a target of 100%; the Kent average from this audit was 94%); babies received a documented consultation with parents within 24 hours of admission to the neo-natal unit (75% against a target of 100%; the Kent average was 85%). The trust was not an outlier in any of the standards of this audit.
- The trust performs worse than the England average in the Nation Paediatric Diabetes Audit (NPDA) in controlling blood glucose levels. The trust had 15.9% proportion of children with a glycated haemoglobin (HbA1c). This compared with the national average of 18.5%.
- The trust had a slightly lower emergency readmission rate at 0.7%, than the national average of 0.8%. Overall, multiple re-admission rates for children with long-term needs was similar to the national average. Multiple re-admission rates for children aged 1-17 years with asthma were 17.6% compared to the England average of 17.3%. The multiple re-admission rate for diabetes was 11.4% compared to the national average of 14.6%. The multiple re-admission rate for epilepsy was 32.8% compared to the national average of 28.6%. We saw that the service had suitable discharge planning arrangements in place to reduce the likelihood of patients being readmitted.

Competent staff

- Information we saw on the trust's balance scorecard showed that most staff had received an appraisal in the last 12 months. Staff we spoke with during the inspection confirmed that they had received an annual appraisal. All of the nursing staff we spoke to told us they felt well supported by their ward teams and the senior nursing and managerial staff.
- Junior medical staff reported good access to teaching opportunities and said that they were encouraged to attend education events.
- We saw that staff had the right qualifications and had access to further development. For example, Padua Ward at WHH had 11 HDU trained Nurses currently employed. The HDU is linked to the ITU at the WHH site and to the South Thames Retrieval Service from the Paediatric intensive care unit (ICU) at the Evelina Hospital, which is part of the Guy's and St Thomas NHS Foundation Trust.

Services for children and young people

- The matron at WHH told us the trust did not provide HDU training for staff; but, this was being reviewed and discussions were in progress with a local university to provide this training.
- The trust had an on-going training programme training staff in European paediatric life support (EPLS) and advanced paediatric life support (APLS) courses. Theatre staff including anaesthetists were trained in paediatric life support.
- The nursing staff in the NICU had access to in-house training and a neonatal life support course. The junior doctors in the unit reported that they received good educational supervision' and said that the consultant staff took an active interest in their learning.
- On Padua ward, staff were routinely required to care for young people who required support from and external provider of children and young people's mental health services. Staff told us they were not trained to care for patients with these specialist needs and they found it challenging to cope with at times. Staff said discussions with child and adolescent mental health services were on-going in regards to them providing appropriate placements for these young people. The trust informed us that all young people with identified mental health needs were risk assessed by child and adolescent mental health services. Where a child was admitted as an inpatient and had identified mental health needs, the trust would employ a registered mental health nurse (RMN) with paediatric experience from an agency to provide care.
- The medical staff we spoke to all confirmed that they had received an appropriate induction when they started work and had an appraisal to identify training needs. Staff said they received access to clinical supervision and good training opportunities.
- Nursing staff told us the practice development nurse or ward manager regularly assessed their competence in medicines management and drug insertion. The trust had recently introduced six monthly supervision days for Band 5 nurses.
- The trust informed us that across the trust all qualified nursing staff who had dealings with children were trained and had annual updates as part of their role specific annual training in the use of PEWS.

Multidisciplinary working

- Paediatric trained staff were available in A&E between 8am and 8pm. Staff told us this was when the majority of children attended A&E.
- There was evidence of multi-disciplinary team working in all departments, within and outside services. There were regular weekly multi-disciplinary team meetings. We also saw evidence of engagement with external agencies such as social services and networking with other children's services to share specialist expertise. For example, the trust's safeguarding lead had liaised with the KSCB to produce multi-agency safeguarding procedures.
- Nursing and medical staff worked closely with the clinical psychology team for children with complex needs throughout the referral, discharge and transition processes.
- The pharmacy, dietetic and physiotherapy teams were children and young people's specialists and joined ward rounds. The service had support from children and young people's physiotherapists.
- The trust employed two full-time qualified play specialists. Play specialists were an integral part of the children and young people's ward and department teams. Play specialists work with children to make the hospital environment welcoming and fun. The play specialist told us they answered questions children may have about what will happen on the ward and offered reassurance. The play team were informed of all planned admissions at handover, and were involved in multidisciplinary ward rounds, as necessary.
- The outpatient clinics and play specialist teams told us the play specialists would support children in any part of the hospital upon request.
- The NICU had an outreach service, where babies discharged from the unit were supported by the neonatal team in the community. The neo-natal team worked closely with community based services such as health visitors and GPs to ensure care was transferred effectively to community services.

Services for children and young people

- We noted that young people up until the age of 16 were cared for within the service. Staff told us that young people over the age of 16 would be consulted about whether to remain on a children's ward or whether an adult ward would be more suitable.
- Surgery services included: general surgery and ophthalmology with a dedicated paediatric consultant and paediatric anaesthetist. Other services included: ear, nose and throat (ENT) surgery and dental surgery. Surgery staff told us they had good working relationships with staff on the children and young people's wards and communication was effective. The trust informed us that they were working towards paediatric only surgery lists.
- The staff we spoke with said that there were good working relations with the local authority social work department and children were seen and assessed in a timely manner.
- Children and young people's services attended six monthly meetings with WHH oncology staff and staff from the Royal Marsden hospital.

Seven-day services

- There were consultant ward rounds seven days a week on the children and young people's wards, and they were available out of hours through on-call arrangements. This meant that patients would have round the clock access to a specialist consultant.
- Padua ward operated a 24-hour service. Channel day surgery ward was used mostly for day case surgery and would closed at weekends.
- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday. There were pharmacists on call out of hours.
- Physiotherapy services were available seven days a week. Out-of-hours support was available through an on-call system.

Access to information

- Information leaflets, 'You and your personal information', explained patients' rights to see their medical records. The leaflet provided details of how people could contact the trust's healthcare records team. The leaflets were widely available across WHH and the children's wards.
- Senior staff were aware of the trust's Caldicott Guardian; this is an appointment whereby the holder has responsibility to ensure the protection of patient confidentiality. This meant patients could be sure that their confidential records would only be shared appropriately.
- Patients' records were available to staff on the wards. Staff had access to policies and guidelines via the trust's intranet. The PAS provided staff with information on children where there were safeguarding concerns.

Consent

- Consent documentation we viewed had been completed appropriately. Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding.
- Staff we spoke with were aware of Gillick competence, this is a decision whether a child 16 years or younger, is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff told us they would always speak with a child and encourage them to involve their parents where appropriate; but would respect the rights of a child deemed to be competent to make a decision about their care or treatment.

Are services for children and young people caring?

Good

Feedback from children, young people and families who used the service was mostly positive about the way staff treated people. Children and young people were treated with dignity, respect and kindness during interactions with staff and relationships with staff were positive.

Children, young people and their families were involved and encouraged to be partners in their care and in making decisions, with any support they needed. Staff spent time talking to children, young people and their parents. Children and young people were communicated with in a way they could understand. Children, young people and their families understood their care, treatment and condition. Parents told us staff worked with them to plan care and share decision-making about care and treatment.

Services for children and young people

Staff responded compassionately when patient's needed help. Staff took appropriate steps on the ward to ensure patient's privacy and confidentiality was respected.

Staff helped children, young people and their families to cope emotionally with their care and treatment. Patient's social needs were understood. Children and young people were supported to maintain and develop their relationships with those close to them, their social networks and community. Parents were facilitated to stay on the ward over night or in accommodation specifically provided for parents.

Compassionate care

- Throughout our inspection, we observed positive interactions between staff, parents and children. We saw staff responding in a considerate manner with children, young people and their families in all of the areas we visited. We saw that staff spent time with children, young people and their parents to ensure they understood their care and treatment, and were supported throughout their time in hospital whether as an inpatient or an outpatient.
- We viewed the friends and family test (FFT) results for WHH paediatric medicine service for the period 1-31 May 2015. The NHS FFT is an opportunity for patients to provide feedback on services that have provided them with care and treatment. We saw that 23 patients or their relatives had responded to the survey in May 2015; of these 78% had responded that they were likely to recommend the service to their friends or family; 22% had responded that they were unlikely to recommend the service. This meant 4 of the 23 respondents were unlikely, whilst 3 out of the 23 were likely to recommend the service and 15 out of 23 were extremely likely to recommend the service.
- Most of the parents we spoke with told us they felt very involved in their child's care. We saw medical and nursing staff on Padua ward and in the hospital's surgery spending time with children, young people and their parents to ensure they understood their care and treatment. A parent told us, "They've all been kind; but, the nurses have been brilliant."
- NICU had been involved in the Picker Institute Neonatal survey 2014. This was a survey of parents' experiences of neonatal care and involved 72 NHS trusts and 88 hospital neonatal units in England. We viewed the survey results and saw that WHH was in line with the national average for most questions posed by the survey. WHH did better than the national average in regards to parents choosing to breast feed their babies; and staff giving parents information about parent support groups, such as Bliss or other local groups. The trust scored slightly worse than the national average for: a member of staff from NICU talking to parents about what they expected after the birth of their baby.
- All of the parents we spoke with told us they felt involved in planning and making decisions about the care and treatment of their child.
- We saw that children and young people's privacy and dignity was respected by staff drawing curtains when providing intimate care or treatment. Staff response to buzzers was timely. Play specialists worked with nursing staff on the Padua ward and Channel day surgery to ensure that children and young people were not left unsupervised for prolonged periods when they didn't have a parent or carer visiting.
- The Padua ward manager told us how the play specialists and ward staff were involved in planning and supporting Christmas parties and Easter activities with children and their families.

Understanding and involvement of patients and those close to them

- All of the patients and parents we spoke with said that they had been involved in their care and in making decisions around their treatment. A parent told us, "They do ask your opinion on treatment. We haven't felt excluded at any time."
- The average length of stay for emergency admissions of children and young people aged between 1-17 years was in line with England average. The service provided in patient care for children up to the age of 16. Staff told us 16-17 year olds would be given the choice of admission to an adult or a paediatric area according to bed availability, providing they did not display behaviour unsuitable for a children's ward environment. Staff said this would always be decided in consultation with the young person and their family. There were single sex adolescent wards available on Padua ward. As well as an adolescents lounge which contained a TV, sofa, and games console?

Services for children and young people

- Play specialists told us children were asked about the activities they would like to be involved with on a daily basis. We saw a play specialist asking a number of children on Padua ward what activities they would like to be involved in. We also saw a play specialist asking children about their preferred activities when playing in the Padua ward play room.
- During our visit, we observed staff communicating with children and parents to ensure they understood their care and treatment. Most parents we spoke with told us they felt well informed and could ask any questions of the staff if they wished to do so. We observed a consultant ward round on Padua ward, and saw staff encouraging parental involvement. We saw a parent asking a consultant questions during a ward round. The consultant responded appropriately to the parent's questions, providing information and advice.
- We observed how staff talked and explained procedures to children in a way they could understand. We observed a number of examples of compassion and kindness shown by staff across all the departments and ward areas. For example, we saw a four year old who had undergone surgery. The consultant explained in accessible language to the child what staff would need to do to ensure the child could go home that day.
- Staff told us that interpreters were available if children, young people or parents required interpreters. Staff had access to a telephone interpreting service. However, staff said the hospitals own staff would be approached to interpret in the first instance via a request by email or the hospital tannoy.
- We noted that there was information available in all the wards and departments for parents. However, there was limited information in a child friendly format. The senior matron told us the trust had identified a lack of child friendly information and that child friendly leaflets were being drafted.

Emotional support

- It was evident from our discussions with staff that they were aware of the need for emotional support to help children and families cope with their care and treatment. All the parents and relatives we spoke with confirmed this during our discussions with them. The nursing staff on Padua ward received a lot of positive comments from parents in regards to providing parents and children with emotional support. Parents we spoke with told us the practical and emotional support provided by nursing staff was valued by them.
- Staff were aware of how anxiety can impact the welfare of the child and made provision, where needed, to manage this. For example, play specialists were able to explain how they used distraction techniques with pre-operative children to alleviate the child's anxiety.
- Parents we spoke with told us they felt confident in leaving the wards and leaving their children in the care of the staff on the wards. However, most parents we spoke with told us they stayed on the ward with their child, either on a temporary bed at the side of their child's cot or in one of the WHH parent's bedrooms.
- Children and young people who were experiencing mental or emotional distress had access to child psychologists. We observed staff on NICU and SCBU attending babies who cried in a timely way to offer comfort.
- The ward manager told us the hospital chaplaincy would offer support for parents and others close to a child who had received bad news. Nursing staff told us they had received training in breaking bad news during their induction. Staff told us the chaplaincy team had access to multi-faith support for children, young people, and their families where there was a need. The chaplaincy was available 24 hours a day, 365 days a year.

Are services for children and young people responsive?

Good

Children and young people's needs were met through the way services were organised and delivered. The importance of flexibility, choice and continuity of care was reflected in service provision. The needs of different patients were taken into account when planning and delivering care and treatment. Care and treatment was coordinated with other services and other providers.

Services for children and young people

Children and young people could access the right care at the right time. Access to care was managed to take account of patients' needs, including those with urgent needs.

The appointments system was easy to use and supported people to make appointments.

Waiting times, delays and cancellations were minimal and managed appropriately. Services ran on time. Patients were kept informed of any disruption to their care or treatment.

It was easy for people to complain or raise concerns and they were treated compassionately when they did so. Complaints and concerns were always taken seriously, responded to in a timely way and listened to. Improvements were made to the quality of care as a result of complaints and concerns.

Service planning and delivery to meet the needs of local people

- The RCPCH's comprehensive review of children and young people's services had offered the trust recommendations for improvements. We saw that the trust had implemented or work was in progress to implement some of the recommendations from the RCPCH, including extended working hours for consultants.
- The trust had considered consolidating children and young people's services into a single site. At the time of our visit services were undergoing review and no decisions had been reached about the geographical locations of children and young people's services in the long-term.
- Services at WHH were flexible and developed with the needs of local children in mind. For example, the NICU had developed an outreach service for families who required support in the community. Discharged babies with complex needs would be supported by staff from the neonatal team prior to being transferred to community nursing services.
- Padua ward had a room that had been furnished and decorated for adolescents. Young people could watch television or videos in the room. Padua ward also had a play room for younger children with toys and a selection of children's books.
- Staff told us that all young people over the age of 16 would usually be consulted without a parent being present, but could have a parent present if this was their preference. Children and young people under the age of 16 would have their capacity to understand information assessed in accordance with Gillick competency. However, staff said they would encourage all children and young people to involve parents where appropriate, so that children and young people could have family support.
- Accommodation was available for parents who needed to stay on the hospital site. We viewed the parents' rooms and saw these were clean and appropriately furnished. A kitchen was available to parents. This was stocked with tea and coffee. Staff told us the parent's rooms would be allocated on the basis of prioritising parents with children in the greatest medical need.
- Information for parents on access to patient records was available on Padua ward and NICU. This explained people's rights to access medical records under the Data Protection Act 1998.
- The outpatients ward had a new purpose built waiting area for children. This had a play area and was waiting for stocks of toys to be delivered. Staff at the outpatients department told us play specialists from Padua ward had advised them on toys and book stocks for the children's waiting area.

Access and flow

- We viewed the trust's children and young people's quality dashboard. This recorded that 100% of children and young people received an outpatient's appointment within 13 weeks of referral.
- Children and young people's services had produced a number of flow charts for patients which would assist them, as well as staff, to map the patients journey through the service. For example, there was a flow chart that provided guidance for staff in A&E on the referral process for rapid referral to paediatric services. The Channel day surgery also had a flow chart; this mapped the patient's journey from admission to the day surgery through to discharge.
- NICU had transfer and admission policies in place; this gave staff clear clinical guidelines and explained the criteria for a baby being admitted to the NICU.

Services for children and young people

- Padua ward had a short stay children's assessment unit (CAU), this provided children and young people aged from 0-15 years with timely initial assessment and diagnosis. The CAU had standard operating procedures in place which provided staff with guidance on access and transfer of patients from the CAU. The CAU accepted appropriate referrals direct from: A&E staff; GPs (including the out of hours service); walk-in centre nurses; community paediatricians; midwives; health visitors; and, by agreement other appropriate referrers working to agreed clinical guidelines, which required an urgent general paediatric opinion due to a child being acutely unwell.
- NICU staff told us they discussed planned deliveries of babies with the anti-natal service and delivery suite on a daily basis.
- We did not see the overall average occupancy level for NICU in the previous 12 months. However, the trust informed us the average occupancy in NICU at WHH in June 2015 was 92%. However, the trust informed us that June was a busy month, and occupancy in May was 85%. The optimum occupancy level for NICU is 70% according to BAPM recommendations. This meant the availability of emergency cots and provision of optimum safe nursing levels on NICU was above the levels BAPM recommends in both June and May 2015.
- The trust informed us that Padua ward's optimum occupancy was 80%. In June 2015, the occupancy rate at midday averaged at 89%. The occupancy rate at midnight was 81%. The trust added that June was a very busy month. In May midnight occupancy was 71% and April was 58%, which was more typical of the overnight bed usage. The average occupancy rate for 2014 was 61% at midnight.
- In outpatients department we saw that clinics were busy but provided a flexible service. Parents we spoke with said that there had been no problems with appointments on the whole and that they were seen reasonably promptly in the clinic. Waiting time for outpatients departments were: surgery eight weeks; rheumatology eight weeks; neuro-disability and ophthalmology nine weeks.
- GP's were informed of patients discharge on the day of discharge. Care summaries were sent to patient's GP on discharge to ensure continuity of care within the community. GP's could telephone consultants and registrars for advice following discharge.
- Staff we spoke with told us that if care and treatment needed to be cancelled or delayed. They would contact the children or young people's parents/carers and explain the reasons for the cancellation and explain that they would be offered a new appointment at the earliest opportunity.
- WHH surgery was using the world health organization (WHO) safe surgery checklist. The checklist identifies three phases of an operation: before anaesthesia, before operation commences and before the patient leaves the operating room. In each phase, a checklist coordinator had to confirm that the surgery team had completed the listed tasks before it proceeded with the operation.
- The trust had slightly lower or similar emergency re-admission rates for all recorded specialities other than non-elective general surgery, which was much higher than the national average, but this may have been due to low numbers of children and young people receiving this service.

Meeting people's individual needs

- Each children's ward and department catered for the needs of individual children. This included ensuring that there was enough space next to each bed or neonatal cot for a parent to visit. There was accommodation available for parents to stay on the ward with children overnight.
- The service used personal child health records (PCHR), referred to as red books. Parents were encouraged to bring these books to each hospital appointment or admission in order to facilitate sharing of child health records and hospital admissions.
- There were sufficient play areas on the wards. Staff we spoke with told us that the service was flexible enough to meet the needs of all children admitted to the wards, regardless of the complexity of their physical needs. We observed good facilities for children with disabilities. For example, Padua ward had a sensory playroom for younger children and children with learning disabilities.

- Support was available for children with learning disabilities or physical needs, with access to registered learning disabilities nurses, as required.
- There were limited age appropriate leaflets and booklets for children and young people that explained the different procedures they could have, as well as medical or surgical conditions. The senior matron told us the trust had identified the lack of child accessible information and work was in progress with the trust's communications team to address this.
- Staff told us that the hospital had access to interpreters if required and information in other languages for people whose first language was not English. We did not observe any interpreters being used during our inspection.
- The trust's play specialist team worked alongside nursing and medical staff to provide support to children and young people. Parents spoke highly of the play specialist service and how they had helped with treatment.
- The parents' area on the children's wards and outpatient departments provided a good range of written information about treatment and care for a range of conditions.
- There were adequate facilities for breastfeeding mothers, throughout children's services.
- All of the inpatient areas had facilities for a parent to stay overnight and sleep. These included pull-down beds next to the child's bed. There was parental accommodation for parents whose children had to stay in hospital for a long period of time.
- The matron and Padua ward manager told us that work was on-going with child and adolescent mental health services to identify a safe place at the trust for children awaiting an appropriate mental health bed. In the interim a registered mental health nurse (RMN) would be employed to provide support for children and young people who had identified mental health needs.

Learning from complaints and concerns

- Complaints were managed in accordance with trust policy. Staff and managers on the children's and young people's wards told us that they preferred to resolve concerns immediately. Staff said these were not recorded, but if they could not deal with the concern immediately parents would be directed to make a formal complaint. Parents we spoke with all said that they had not raised any complaints with the service. Most parents we spoke with told us they thought staff would be approachable if they wished to raise issues. The Padua ward manager told us they always spoke in person to anyone who raised a complaint.
- Information regarding complaints and concerns was on display in wards and departments we visited. Leaflets detailing how to make a complaint were freely available. We only saw leaflets in English. This meant non-English speakers would have to request information on how to make a complaint from the ward staff.
- The service held monthly governance meetings. The minutes of these meetings showed complaints to the service were a standing agenda item and would be discussed at the meetings. We saw that complaints were discussed in the child health quarterly report. For example, in the January 2015 report 11 formal complaints had been received across the trust's children and young people's services. We saw that complaints were monitored and themes identified. Learning from complaints had been identified and procedures had been put in place where a complaint had been upheld. For example, we saw that as a result of complaint new procedures for the care of children following a tonsillectomy had been introduced, including staff using a 'situation-background-assessment-recommendation' (SBAR) tool. SBAR is a tool that enables staff to clarify what information should be communicated between members of a team, develop teamwork and foster a culture of patient safety.
- The Padua ward manager told us that all formal complaints were logged through the patient liaison service (PALS). Themes from complaints were monitored at governance meetings and by PALS.

Are services for children and young people well-led?

Requires improvement

The leadership was knowledgeable about quality issues and understood what the challenges to children and young people's services were, and took action to address them.

Services for children and young people

The values for children and young people's services had been developed with elements such as compassion, dignity and equality. However, there was no long-term vision or strategy in place for children and young people's services. The trust had conducted a recent strategic review of children and young people's services, and concluded that the proposed strategy of children and young people's services operating from one site was not viable. At the time of our inspection there was no decision pending on what the vision or strategy would be for children and young people's services.

Children and young people's staff were unaware of the service's strategic goals as the trust had not made a final decision about the future strategy for children and young people's services.

The board and other levels of governance within the organization had undergone changes in the past 12 months. The chief nurse and director of quality had been instated as the children and young people's services lead. The service's structures, processes and systems of accountability were set out and understood by staff.

Leaders at every level prioritised safe, high quality, compassionate care and promoted equality and diversity. The culture change programme encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. However, staff reported that ward managers for children and young people's services had been overlooked for administrative support.

There was evidence that the leadership had introduced processes that would actively shape the culture through effective engagement with staff, people who use services and their representatives and stakeholders. Senior leaders encouraged a culture of collective responsibility between teams and services. But, these processes were not embedded.

The children's and young people's service was proactively engaging with and involving all staff to ensure that the voices of staff were heard and acted on. Safe innovation was being supported and staff had objectives focused on improvements.

Vision and strategy for this service

- Safety and quality were clearly the top priorities for the management team. However, the trust had undertaken a lot of work on the children' and young people's strategy in regards to a proposed move to a single site with area hubs. Staff told us this strategy had been abandoned in the week prior to our visit due to a central location being required and this being prohibitively costly. Staff told us the trust were now looking at care and treatment to be provided in two locations; but, a decision had not been finalised on the future strategic direction for children and young people's service.
- The chief nurse was the non-executive lead for children and family services. The chief nurse had regular meetings with children and young people's staff. Staff told us the chief nurse was visible and approachable.
- The nursing and medical management team were aware of how they fitted into the wider management model for the trust. We saw "Who's who" posters displayed in the WHH corridors; these had photographs of the council of governors' members and board of directors as well as flow charts to enable staff's understanding of the structure of the trust's senior management team.
- Most of the staff we spoke with were aware of the vision and values of the trust, and said that they felt they were kept informed. Staff told us the trust's vision and values were communicated on the trust's emails. We saw posters displayed on the wards that communicated the trust's vision and values.

Governance, risk management and quality measurement

- There was a governance framework in place and responsibilities were defined. The clinical governance committee met monthly and was primarily concerned with the delivery of safe, high quality patient centred care, and to provide assurance to the children and young people's division that key critical clinical systems and processes were effective and robust. The systems that were regularly reviewed by the committee included: performance; incidents; risk; patient experience; quality improvements and sharing best practice; guidance and frameworks; health and safety updates; and information governance.
- A risk register was in place which identified the key concerns for children and young people's services across the trust. There were 16 items on the register. Most staff we spoke with were aware of the risk register.

- The trust's child health senior management team held a monthly governance meeting. The risk register was a standing agenda item and up-dates were provided on all identified risks. Where risks had been mitigated they were removed into the risk register's removal folder with reasons for the removal. The governance meetings were minuted with action points; and minutes were distributed to committee and non-committee members across children and young people's services.
- Children and young people's governance meetings reported into divisional quality and governance meetings by way of an exception report. The minutes of these meetings were fed back directly to the quality assurance board with the exception report.
- The trust used a balanced score card to monitor services. The balanced scorecard is a strategic planning and management system that is used to align the trust's activities to the vision and strategy of the organization, improve internal and external communications, and monitor organization performance against strategic goals. The balanced scorecard was monitored by the chief nurse and senior matron.

Leadership of service

- Consultants' roles and responsibilities were defined by the trust's job planning process.
- The children and young people's matron was matron at the WHH site, QEQM hospital site, the Kent and Canterbury children's assessment unit, and Buckland hospital. The matron's office was based in QEQM, which was a 40 minute journey by car to WHH. The matron told us they visited WHH on a weekly basis or more frequently if required. However, this meant staff on Padua ward were at risk of not having face to face access to an on-site matron for a large part of the week. It also meant the matron was monitoring services at WHH from a distance for most of the week, as well as monitoring other children and young people's services across multiple sites. It was therefore difficult for them to have sufficient presence in all the trust's children's and young people's locations.
- The Padua ward manager was supernumerary. The ward manager told us this allowed them to provide assistance on the ward or in other departments if required. The Padua ward manager was also managing the children and young people's service at Buckland hospital. This meant the ward manager needed to allocate time in the week to dealing with Buckland tasks.
- We noted that on one occasion a ward manager at WHH was out of uniform and wearing casual clothing. The manager told us this was because they were working in the office completing administrative duties on that day. However, this meant the manager was not dressed in accordance with the trust's policy on uniforms. It also meant the ward manager would have been unable to assist if they had been required to assist on the ward or in another department. Some staff told us the trust had provided ward managers across the trust with additional administrative support, but that children and young people's wards were over looked for additional administrative assistance. Staff said this meant children's ward managers were spending more time on administration and less time on the wards.
- Staff told us that leaders at the locality level were visible and approachable. We observed the matron advising ward managers and staff on the children and young people's wards on several occasions. A ward manager told us they had regular bi-monthly meetings with the matron.
- The chief nurse and director of quality had been appointed as the children and young people's lead on the board of directors. Senior ward staff we spoke with said that they felt supported by senior management, and if they raised any concerns about the service, they would be listened to. Staff told us that the board of directors were more visible on the wards than they had been.
- There were governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service. We looked at copies of governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These showed that there were management systems in place that enabled learning and improved performance, and these were reviewed on an on-going basis.
- We saw local clinical leaders and managers encouraging supportive, co-operative relationships among staff and teams, and compassion towards patients.

- There were regular bi-monthly site meetings at WHH. The key purpose of these meetings was to disseminate information from the senior management governance meetings to all staff at service delivery level. We did not view minutes from these meetings.

Culture within the service

- The trust had embarked on an improvement agenda. This included the launch of a culture change initiative in January 2015. As part of the culture change initiative the trust had developed an information hub at WHH. The hub was staffed one day a week by members of different departments and teams. A staff member told us this encouraged teams and departments to get to know each other, develop better working relationships, and to facilitate channels of communication between departments and teams. We saw that staff from Padua ward regularly attended the hub sessions.
- Most staff we spoke with reported that relationships between departments had improved; but, some staff we spoke with told us they didn't think all staff had embraced the trust's change agenda. A staff member told us, "We are trying to shift away from working in silos."
- Children and young people's staff told us that there was a positive culture within teams, and that staff supported each other well. We saw that staff worked well together in multidisciplinary teams to provide holistic care to children. Staff told us the culture of the service was focused on meeting the needs of children, young people and their families. A member of staff told us, "From where we were 12 months ago; it's like working in a different trust. Things have definitely improved."
- Staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their manager. Staff we spoke with told us they felt able to raise concerns. None of the staff we spoke with said they had experienced bullying from their colleagues or supervisors. However, a member of staff on the medical team told us some staff could communicate better with their colleagues when teams were busy and under stress.

Public and staff engagement

- The trust informed us that they used the Friends and Family Test (FFT) and the Picker survey to collect feedback about services.
- Most of the parents we spoke with told us they had been actively involved in decision making. For example, a parent told us they had attended A&E and had been fully consulted about their child's assessment and admission to Padua ward.
- Staff we spoke with told us the trust had held focus groups with staff in regards to the trust's change agenda. Staff told us the trust had held a number of focus groups in the past 12 months. The chief nurse and director of quality had also visited the children's wards at WHH and spoken with staff.
- An information hub had been launched at WHH. Staff told us an aspect of this was to engage staff with the trust's change agenda.

Innovation, improvement and sustainability

- The trust had introduced a culture change programme, 'let's make our trust a great place to work.' The trust outlined to staff that the programme was the beginning of a long-term and sustainable change at the trust to ensure staff felt supported and inspired about working for the trust. The trust was publishing regular updates, 'our improvement journey', which explained some of the initiatives across the trust to help the trust achieve improvement goals. All the staff we spoke with were aware of the culture change programme, and most reported that the culture at the trust was improving.

End of life care

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

Information about the service

The William Harvey Hospital had a specialist palliative care (SPC) team led by a nurse consultant in palliative care who worked across all three acute hospital sites. In addition there were two clinical nurse specialists (CNS), two counsellors and a social worker on this hospital site. The SPC team was supported by a medical palliative care consultant from the Pilgrim's Hospice.

The SPC team were available Monday to Friday from 9am to 5pm. Outside these hours support was provided by the Care of the Elderly team and telephone support by the hospice. There were 1,070 deaths in the William Harvey Hospital from April 2014 to March 2015.

We visited a variety of medical and surgical wards including: Cambridge J, K, L and M, Kings B, C and D, Richard Stevens, Kennington, Oxford, Rotary and Critical Care. We also visited the mortuary, patient experience offices, the Chapel and the porters lodge. We reviewed the medical records relating to the end of life care of six patients and eight Do Not Attempt Cardio Pulmonary Resuscitation forms in addition. We observed care on the wards and spoke with six patients receiving end of life care as well as two of their families. We received comments from public events we attended and from people who contacted us individually to tell us about their experiences. We spoke with 39 members of staff that included porters, admin staff, senior and junior doctors, nursing staff of all grades and managers of services. We reviewed other performance information held about the trust.

Summary of findings

The trust's specialist palliative care team demonstrated a high level of specialist knowledge. The team provided individualised advice and support for patients with complex symptoms and supported staff on the wards across the hospital. We found reduced resources for the team and concerns regarding sustainability of the service. The planned improvements could not be implemented on current resources.

There remained a lack of Trust Board direction for end of life care with a non-unified approach across the various wards and departments. There was limited end of life care training and use of the trust resource pack was patchy and not kept up to date. Wards struggled with staffing levels and there were no extra staff in place to support end of life care.

All staff we spoke with, both clinical and non-clinical, demonstrated a very high level of care, pride and attention to detail in the provision of a good quality service for patients identified as end of life. Patients and families we spoke with described good quality care from staff. The trust worked with the East Kent regional strategy in line with evidence based practice and guidance.

End of life care

Are end of life care services safe?

Requires improvement

The trust had an incident reporting system in place that staff were aware of and used. However, the electronic systems supporting this were described as very slow. We found that incidents reported did not reflect the number of concerns raised when we spoke with staff. Staff raised specific issues regarding changes in the last rights process and introduction of new equipment that identified conflicting training and guidance for different staff groups.

Medicines were well managed, however the trust were using out of date syringe driver prescribing and record of administration forms. Record keeping was of a good standard for patients identified as at end of life. Identifying patients at end of life was sometimes delayed and there was on-going work and audits to raise awareness with staff. The Liverpool Care Pathway had not been replaced and there was poor end of life document management.

The Specialist Palliative Care Team (SPC) were not able to provide out of hours cover. Telephone advice was available from the local hospice and there was some support from the Care of the Elderly Team within the hospital. A palliative care consultant from the local hospice provided limited medical services in hours.

There was a well-managed mortuary in a clean and ordered environment. Record keeping was to a high standard.

Incidents

- There was an electronic incident reporting system in place that all staff we spoke with were aware of including administration staff, doctors, nurses, mortuary staff and porters. However, we were told that the IT systems generally were very slow and frequently did not allow access. The incident reporting system was described to us as, “Slow and clunky.”
- Porters were employed by a company contracted by the trust and did not have direct access to the trust electronic system but reported into their company system. We were told that there was one person within the company responsible for ensuring that relevant incidents were entered on to the Trust system.
- The Trust and the contracted company provided us with reports on incident reporting that related to the transfer of deceased patients or to the mortuary.
- The contracted company report for the time period 7 November 2014 to 4 June 2015 consisted of five incidents, one of which related to William Harvey Hospital (WHH) with appropriate action and learning completed.
- The Trust reports for April 2014 to July 2015 consisted of 19 incidents, three of which related to WHH. All had actions and learning recorded with two making reference to confusion regarding recent changes to the last rights procedure.
- At the focus groups as well as during the inspection staff described a lack of clarity regarding the recent changes in equipment and in the last offices procedure. The number of reported incidents did not reflect the number of issues staff raised with us.
- We were provided with examples of recent incident reporting. One occurred in the mortuary where the full identity checking process was not completed. This was recognised promptly and corrected. The incident was reported and investigated. We saw appropriate actions had been taken, for example the standard operating procedure was amended.
- We found a lack of full understanding and knowledge of the legislation regarding Duty of Candour amongst the staff we spoke with. However, staff demonstrated a knowledge and understanding of the requirement to be open with patients and families where an error had been made and the importance of involving them in results and actions from any subsequent investigation. Staff provided examples where they had had such discussions with patients and families.

Environment and equipment

- The mortuary had a coded entry system in place that porters had access to, with a bell for other visitors to the area. There was restricted access until 11.30am unless pre-arranged. This was to allow staff to support post mortem examinations.
- We saw that equipment such as fridges and hoists were regularly maintained with records kept. We saw that the hoist had been calibrated on 16 June 2015. Trolley checks were seen and fridge service carried out on 15 April 2015.

End of life care

- There was an alarm system in place to ensure that the fridge temperatures were always within the correct temperature range.
- We saw that weekly cycle checks were undertaken and recorded for the sterilising equipment in the post mortem room.
- There was a good supply of personal protective equipment such as gloves, as well as cleaning products and wipes. The area was cleaned to a high standard.

Medicines

- The two clinical nurse specialists were nurse prescribers which meant that, for the end of life care patients they were managing, appropriate medicines could be prescribed and administered in a timely manner.
- We saw examples of anticipatory medications prescribed for end of life care patients in the medical records we looked at.
- We observed controlled drugs being administered to two patients on one of the wards we visited. There were two nurses present, appropriate checking of patient details was undertaken and the controlled drugs book and patient's drug chart signed.
- The trust were using out of date syringe driver prescribing and record of administration forms. These referred to two types of pumps no longer used in the trust.

Records

- We reviewed a random selection of six patient records and an additional eight DNACPR forms. We found that record keeping was of a good standard. DNACPR forms were dated and signed by senior doctors, were clear whether the patient had mental capacity or not and demonstrated discussion with patients and/or families. These decisions and discussions were also documented in the patient record.
- The trust had a specialist palliative care referral form and we saw these well completed in patient records we looked at.
- We saw the multidisciplinary checklist summary for patients being discharged from hospital at the end of life with rapid discharge home guidelines and that these had been completed.
- We saw a high standard of record keeping in the mortuary. All registers, signing in books, boards and checklists were properly completed and monitored. There was a well ordered system for documents including maintenance and training records.

Safeguarding

- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults.
- Safeguarding e-learning was part of mandatory training and this was monitored by the ward managers.
- The relevant local authority and social services contact numbers were available for staff.

Mandatory training

- Much mandatory training was e-learning with some face-to-face training such as the practical part of moving and handling training.
- There was significant reliance on e-learning to ensure that staff were updated regularly. However, staff told us that the trust IT systems were not fast or reliable enough to support this training. They described difficulties accessing the courses, the slowness of the system and the completed training was not always saved and recorded by the system. This meant that their managers thought they had not undertaken training and that in turn impacted on their receiving their annual salary increment.
- We saw records of mandatory training in the mortuary that included fire safety, moving and handling, information governance, infection control, equality and diversity and health and safety.
- Porters we spoke with said they received annual updates on mandatory training, some of which was e-learning. Transfer of deceased patients and mortuary procedures were included in their mandatory training. However, we heard of some lack of clarity in the training provided by the external company. The porters said that there were some differences between their training and the ward nurses training with regard to infection prevention and control. The ward staff expected porters to wear gloves and aprons during transfer of the deceased into the concealment trolley whereas the porters said they were told by their company that they should not wear gloves and aprons.
- We followed up with the company management team and were subsequently provided with the Transfer of Deceased Patients protocol. This clearly stated that

disposable gloves should be used before handling a body. Aprons were not mentioned but the protocol stated, "… they shall always ensure they follow infection control procedures at all times …"
- Our understanding was that porters should not wear gloves when pushing the concealment trolley along the hospital corridors but should wear them on the wards. This was not clearly understood by all porters we spoke with.

Assessing and responding to patient risk

- Once patients were deemed to be for end of life care the ward staff tried to move them to a side room on the ward where possible.
- From the records we looked at, identifying patients for end of life care was sometimes delayed. This was also evidenced by the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audits carried out by the trust and included appropriate and rapid escalation in response to the early warning scoring process in place. There was ongoing work and audits in place to raise awareness with staff.
- Once patients were identified for end of life, care and treatment was in place for each patient's needs.
- We found there was no structured approach to end of life care since the Liverpool Care Pathway (LCP) was removed in 2013. However, staff used the principles of the LCP and treated each patient as an individual. The Trust "End of Life Conversation" documentation was not in use at the time. This had been developed to support full discussions with patients and their families on their diagnosis, prognosis and options. Further work to embed the document in practice was underway.
- The exception to this was in Critical Care. There were guidelines and a nursing care pathway with complete documentation including the "End of Life Conversation" document. We saw decisions and discussions recorded in the documentation.
- The end of life care resource file varied from ward to ward. On Cambridge J Ward it was not up-to-date. For example, it contained Symptom Guidance version 4 2009, whereas version 5 was on the Trust intranet. The discharge fast track checklist contained reference to the LCP. On Cambridge L Ward (an elderly care ward) staff were not aware of a resource file or of the five priorities of the dying person. These priorities form part of the Leadership Alliance for the Care of Dying People's document One Chance to Get it Right and sets out the duties and responsibilities of staff involved in the care of dying people. However, conversely, it was fully updated and regularly used on the Stroke Unit.
- Palliative care link nurses were appointed for each ward. However, with staff changes, not every ward had them at the visit. Again we found varied practice. We spoke with one non-registered member of staff who had been the link for palliative care for some years and demonstrated a high level of knowledge and understanding of end of life care. The member of staff also provided training for new non-registered staff on the ward.
- Most of the wards we visited did not keep specific training records for syringe drivers. However on Cambridge M Ward the records were complete and we saw that all staff were trained and in date.
- The Last Offices Policy was not available on all the wards we visited.
- There was up-to-date guidance on symptoms and the five priorities of end of life care available on the Trust intranet.
- On Cambridge L Ward we reviewed an end of life patient's medical records. We found extensive multidisciplinary documentation of investigations and treatment of medical conditions. However, there were no regular assessments of hydration needs.

Nursing staffing

- The Specialist Palliative Care Team (SPC) consisted of a trust-wide nurse consultant with two clinical nurse specialists (one full time and one four days a week), two counsellors and one social worker on each acute hospital site. There was no cover for annual leave or sickness for the nurse consultant role. The nurse consultant covered holiday periods for the clinical nurse specialists.
- The SPCT were unable to provide out of hours cover. Telephone advice out of hours was provided by the hospice. At WHH there were nurse prescribers so they prescribed for the weekends, otherwise the junior doctors covered.
- The SPCT told us that they had to prioritise their time for the more complex patients. They were aware that the ward staff would like more support to reassure them that they were providing appropriate care for less complex patients identified at end of life.

End of life care

- We were informed that nurse recruitment was ongoing and that there were some shortages on some shifts for most wards. Nursing staff described good care for end of life patients but told us that they covered this care within the normal staffing establishment. Staff ensured that patients and families were given the time and support they needed at end of life but this meant that other staff on the shift took on extra patients during this time.
- There were 3.6 whole time equivalent mortuary staff, three of whom were certified morticians. Staff said that they felt there were sufficient staff to provide a good quality service.
- The porters were employed by an external company. Those we spoke with felt that whilst they were busy there was generally sufficient numbers of staff.
- There was one Relative Support Officer working 25 hours per week for the hospital. This was not felt to be sufficient for the winter months with the increased admissions and deaths and had been discussed with managers.

Medical staffing

- There was one palliative care consultant visiting WHH from the hospice. They undertook two ward rounds each week, attended some multidisciplinary cancer meetings and undertook some training.
- There was no medical palliative care consultant cover out of hours.
- We were informed that there was, and never had been, any service level agreement regarding medical time between the trust and the hospice.
- Medical staff we spoke with in Cardiac Care felt that staffing was insufficient at the weekends and at night; they were constantly having to prioritise care and treatment. They did have senior advice available on the telephone at all times.
- We heard that junior doctors received weekly teaching and attended the Grand Rounds.

Major incident awareness and training

- The trust had a business continuity management plan in place with a framework for disruption of services. This covered major incidents such as winter pressures, severe loss of staff, loss of electricity or water.
- Most staff we spoke with were aware of the hospital's major incident plan such as winter pressures and fire safety incidents, and they understood what actions to take in the event of an incident such as a fire.
- Mortuary staff were aware of major incident planning and coordinated the daily storage tracking. There were two overflow fridges that contained 12 spaces with some additional capacity. They could hire up to four more fridges as required to cover the winter period. We were told further discussions were underway.

Are end of life care services effective?

Inadequate

The trust worked with the end of life care regional groups and followed national guidance. The specialist palliative care team demonstrated a high level of specialist knowledge and provided support for patients and staff. Out of hours advice and support was provided by the local hospice.

Trust audits highlighted on-going challenges in identifying and decision making around end of life care. Where decisions were made there was evidence of good multidisciplinary care and treatment. Documentation supporting the five priorities for care at end of life was under development, with patchy use of what was already in place.

Recent changes to the last rights procedure and introduction of new equipment was not clearly consulted with staff prior to implementation. This impacted on the competence and confidence of staff at a sensitive time.

Evidence-based care and treatment

- The trust was part of the four Clinical Commissioning Groups' end of life work stream to improve end of life care across the region. The work was based on national guidance.
- The trust followed the manual for cancer services (2004) that reflected the National Institute of Health and Care Excellence (NICE) guidance for improving supportive and palliative care for adults with cancer.
- There was an SPC team that provided specialist knowledge and worked alongside other specialist nurses in providing evidence based care and treatment.

End of life care

- In September 2014 the SPC provided the trust with a report against the quality statements contained in NICE Quality Standard 13 (QS13) on end of life care for adults. This included the plan going forward within the trust and the wider East Kent end of life care strategy. The report demonstrated that much was still under development within the region, such as the Electronic palliative care register (EPaCCs) originating in primary care and hoped to be implemented in the trust during 2015-2016.
- Audits regarding Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) were undertaken regularly across the trust. These highlighted the need for further improvement in identifying end of life care patients.
- We saw evidence of audits undertaken in the mortuary that included an infection control audit in June 2015 carried out by the estates department and the company providing the portering service. There were bi-monthly observational audits for competencies that had been completed up to February 2015. There was also an audit of the mortuary processes carried out in January 2015.
- We were told that they had passed the last Human Tissue Authority inspection approximately three years ago. A further visit was expected in 2015.
- We saw that where the infection disease status of the deceased was not completed in line with the trust's policy on management of high risk cadavers that these were reported as incidents.

Pain relief

- Pain levels were routinely collected together with vital signs and pain was promptly treated. We saw these recorded in the patient records we looked at.
- One example we observed while on Cambridge J Ward. A patient approached staff to say that they had just started to experience pain. We saw that the patient was given breakthrough opioid (additional dose used to control a transitory flare of pain). We reviewed the patient's medical records and saw that the patient had been referred to the palliative care team, had regular assessments for pain and appropriate medication given frequently and as required.
- Patients we spoke with felt that their pain was well controlled.

Nutrition and hydration

- Patients we spoke with told us the food was good. They said that there were plenty of drinks available at all times.
- We observed that water jugs were full and accessible for patients. Hot drink trolleys were seen on the wards.
- We saw examples where dietary needs had been catered for and patients' food and fluid intake monitored in the patient records we looked at.

Patient outcomes

- Between 28 December 2014 and 18 January 2015 a snapshot audit of Cardio Pulmonary Resuscitation attempts was undertaken at WHH. The audit included the proportion of patients who should have had a DNACPR form in place prior to the arrest and the appropriateness of the decision making. Ten sets of patient records were chosen at random to review. The positive result from the audit was that the nine medical patients included had a consultant review within 12 hours of admission. However, none of the patients reviewed had a DNACPR form in place prior to the arrest, whilst the audit found that in eight out of the ten cases reviewed there was evidence that a form should have been completed. These results highlighted, "...the continuing challenge of timely decision making for patients demonstrating signs of deterioration against a back drop of several co morbidities." The report stated that the results would be fed back to the wards and the EOLC Board.
- An audit of completion of DNACPR forms was carried out in May 2014 at all three acute hospital sites. Results clearly identified good practice and practice that required improvement for each site and trust-wide against the 2013 results. WHH results demonstrated 100% for completion of the reason for DNACPR and signed by a health care professional, to 36% of the forms containing the name of the multidisciplinary members contributing to the decision. Actions and recommendations were included as well as reporting the results to the EOLC Board.
- The surgical wards carry out small audits (six to eight forms) of completion of DNACPR forms at regular intervals with a summary provided to the trust governance lead.
- The trust used an early warning and patient observations system to identify deteriorating patients. The Critical Care Steering Group oversaw the trust's Deteriorating Patient Programme and provided six

monthly reports to the Patient Safety Board. We were provided with the report for the period 1 October 2014 to 31 March 2015. The programme measures a variety of topics that include vital sign recording and compliance with the DNACPR policy. The report reiterated the challenge of identifying and decision making around end of life care.

- The hospital submitted annual data to the National Council for Palliative Care in respect of the Minimum Data Set, a process for monitoring activity. We requested the most recent submission but this was not provided.
- The trust did not take part in the National Care of the Dying Audit for Hospitals 2013-2014. However, we have seen evidence that the trust has registered for the National End of Life Care Audit for 2015.
- We were told that the standard to issue of the Medical Certificates of Cause of Death (MCCD) was within three working days. There was an ongoing audit of times to issue across all three sites. For the period 1 July 2014 to 30 June 2015, 1153 certificates were completed of which 57 were over the three day standard, 29 by just one day. This represented 95% compliance with the Trust standard.

Competent staff

- End of life care e-learning was available on the Trust's electronic training system. We were told that the SPC team provided a variety of sessions for staff over 2013-2014 including the role of palliative care and end of life at a grand round.
- Trust-wide we were provided with information that 10 staff were provided with training, such as 'compassion training', undertaken with the local hospice between January and June 2015.
- Palliative care consultants contributed to Grand Rounds, Schwartz Rounds and In Your Shoes run by the trust.
- A registrar we spoke with said that end of life care was covered in their induction programme. They were aware of the importance of communicating with the family as well as the patient, in particular discussions regarding DNACPR decision making. They felt well supported by the Care of the Elderly Team and their consultants provided advice and support.
- The two palliative care specialist nurses were both nurse prescribers. This meant that medications, for example pain relief, could be prescribed without the need to call a doctor and the wait that could entail for the patient. We were informed that they attended a prescribing update conference in the last year.
- We were provided with evidence that 17 WHH nurses were trained on the syringe drivers in January 2014. These were advanced users, trained to be experts in their ward areas. We were told it was the responsibility of each ward manager to ensure that their staff were trained and competent. Not all ward managers were able to provide evidence of training for staff on their ward. Staff expressed concerns when there were shifts with high numbers of agency staff on the ward.
- We also saw that 10 staff trust-wide had received end of life care training provided by the local hospice between January and June 2015.
- The first trust-wide link nurse meeting took place on 1 July 2015.
- The Relatives Support Officer (RSO) received training on the various processes and protocols from their manager. New staff were supported during their first week. Annual appraisals were carried out and included discussing training needs. The manager was undertaking an IT training course for a software package.
- The RSO worked alone for much of the day. There was a weekly teleconference for all three sites so they could receive updates and have a team discussion.
- We saw records of annual appraisals for mortuary staff held on electronic system for monitoring.
- Mortuary staff told us that there was a Trust counselling service but that they worked well as a team and supported each other.
- Mortuary staff and porters were trained in the use of the newly installed ceiling hoists in the mortuary and all stated that this was a considerable improvement in the prevention of musculoskeletal injury, particularly with the numbers of bariatric bodies to be moved and transferred. However, the training matrix for porters showed that there were 31 staff awaiting training with only seven having completed the training. These figures for completed training were considerably lower than for the other two acute sites.
- Mortuary staff and porters were also trained in the recently acquired green lift sheets used for transferring a deceased person from the bed on the ward into the concealment trolley for transfer to the mortuary, then from the trolley into the fridge. All staff we spoke with in those departments said that this was an improvement

in respect of moving and handling practice. As it is such a recent change some staff were more confident than others. The porters were pleased with the change but said that each transfer took longer than the previous process. This extra time had not been reflected in the task time allowance which remained the same at 20 minutes per transfer.

- On the wards we were told of instances when there was confusion amongst the nursing staff with the new Last Rights policy and use of the green lift sheets. We were told of occasions when the deceased was not fully covered and difficulties transferring to the concealment trolley as a result of the confusion.
- Nursing staff at the focus groups held the week before the inspection visit told us that the Last Offices procedure had changed recently. Many of them said they had not been informed in advance of the changes and had not been trained. Some present in the focus groups were not aware of the changes at that time.
- We received a varied response from the nurses on the wards we visited. Where the ward manager was well informed the guidance was visible and the process was said to be working well. Where staff were not well informed there was evidence of a lack of understanding the reasons for the changes in practice. This meant that dignity was not always protected and caused distress to nurses, porters and mortuary staff when it occurred.
- The concerns were not always with the changes in practice but were always regarding the staff not feeling informed, confident or competent in the new ways.

Multidisciplinary working

- A weekly multi-disciplinary meeting between the three acute hospitals was held via video link. We attended a meeting with the WHH staff. Consultants, palliative care team and a social worker attended. Each hospital had brought complex patients for discussion regarding their care and treatment. Whilst most were cancer patients, patients with non-malignant life threatening conditions were also discussed. We observed good exchange of information and the opportunity to build relationships across the Trust.
- The Specialist Palliative Care Teams worked closely with the local hospices to discharge patients who wished to die in their own homes. We were told of very good working relationships with the hospices.
- They also worked closely with the tumour site specialist nurses, dementia nurse and care of the elderly team.
- Porters (employed by a contracted company), mortuary, patient experience staff and ward staff all described good working relationships. However we did not find evidence of opportunities for joint discussions, particularly where there were changes in such a sensitive area as last rights and transfer of the deceased.

Seven-day services

- The SPC team worked from 9am to 5pm, Monday to Friday. There were insufficient numbers of staff to provide a seven-day service. Outside these hours and at the weekend the local hospice provided telephone advice and support. Wards were also able to access support from the Care of the Elderly Team.
- The mortuary was open 8am to 4pm Monday to Friday. However staff provided a 24 hour on call service seven days a week. Identifying the deceased was available at all times on an as required basis.
- Relatives were supported when attending for a viewing by the Relative Support Officer (RSO) between 10am and 4pm. Outside these hours this service was provided by the Site Coordinator with the support of porters transferring the body from the ward to the mortuary.
- The Chaplaincy service was available 9am to 5pm Monday to Friday with an on-call service from 6pm to 6am for emergencies only. There were two Chaplains on-call at the weekends for the three acute hospital sites.

Access to information

- The trust had access, with patient consent, to GP records through the Medical Interoperability Gateway (MiG) system. They were one of the first trusts in England to have access to this information 24/7. This meant that when a patient arrived in A&E the system automatically flagged up if they were at end of life. The palliative care team monitored the system and the local hospice was informed if the patient was known to them.
- Records for patients identified as end of life contained care plans, anticipatory medications and evidence of multidisciplinary input into care and treatment.
- The end of life care resource folder contained current information and trust documentation. Ward staff told us that they referred to this information. However, not all wards had an up-to-date version and we found some staff unaware of the resource folder.

End of life care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical staff we spoke with understood the DNACPR decision making process and described discussions with patients and families. They tried to provide clear explanations to ensure that the decision making was understood.
- Medical staff understood the Mental Capacity Act and we were shown examples of mental capacity assessments on the clerking documentation.
- One of the patients discussed at the weekly multidisciplinary video link meeting with the three acute hospitals required support from the advocacy service and this was arranged.
- Medical staff were not always clear on the terminology of the Duty of Candour but they all told us they would always inform the patient if something had gone wrong and understood the importance of being open with patients and their families.
- We saw a total of eight DNACPR forms that were filed in the front of the patient notes, fully completed, signed by a senior doctor and demonstrated discussion with the family. One had been reviewed and discussed again with the family as the patient did not have capacity at that time.
- The hospital post mortem consent form was completed on the ward and we saw signed copies in the mortuary office. One form included consent for the removal of specific tissues and was dated 9 June 2015. We saw a trust-wide policy for organ and tissue donation in place.

Are end of life care services caring?

Good

We found a very high level of care, pride and attention to detail in the provision of a good quality service for patients identified as end of life. Staff respect for the deceased in their care was abundantly clear in all parts of the service they provided.

Patients and families we spoke with reflected the good care provided. We were told that they felt included and informed in decisions.

Compassionate care

- Patients we spoke with told us that the care was excellent. The nurses were kind and responsive. They felt their dignity was respected.
- The trust had opened a suite on all three sites specifically for relatives of patients receiving end of life care. They consisted of sitting rooms, a shower and a kitchen with access to a garden. These had been agreed by the clinical management board. They provided a place of quiet and peace for relatives to rest and make themselves drinks.
- The viewing area in the mortuary was clean and of a neutral décor. Staff had added some items such as floral displays to make the area more homely. Between the hours of 10am and 4pm Monday to Friday the Relatives Support Officer (RSO) would accompany relatives to the viewing room and described the support they provided. This was led by the relatives and if they wished to be left alone this was facilitated by both the RSO and mortuary staff. Out of hours the site coordinator would accompany relatives.
- We found a very high level of care, pride and attention to detail in the provision of a good quality service. Staff respect for the deceased in their care was abundantly clear in all parts of the service they provided. This was also reflected in their support of the viewing process for relatives.
- Whilst needing to manage capacity in the mortuary we saw evidence that when families needed extra time to make arrangements this was facilitated.
- We saw that a Relative Support Officer (RSO) compassionately supported parents who wished a burial for their baby less than 16 weeks old.
- We were told how mortuary staff obtained an “Out of England” certificate for a family who wished to take their relative overseas for burial.
- The same high level of care, pride and attention to detail was also evident when speaking with nurses on the wards and with porters who transferred the bodies. All staff were committed to providing a high quality service that respected the dignity of the deceased.
- We were told of a new process for preparing the deceased for transfer and the actual transfer. We received varied reports on whether the deceased’s dignity was fully maintained at all times. Where staff fully understood the changes no issues were raised.

Understanding and involvement of patients and those close to them

End of life care

- We observed several occasions during the visit where patients and relatives were provided with clear and comprehensive information and support. Examples included patient reassurance and explanation regarding discharge planning as well as advice and support for those recently bereaved.
- Patients we spoke with told us that they felt well informed and involved in their care and treatment.
- One patient told us that they were amazed so many doctors were interested in them. The DNACPR had been discussed, as had their preferred place of death. They and their family felt fully informed.
- One patient's family members described how the staff had worked hard to communicate effectively with their relative who suffered some disabilities.
- We saw "You said – We did" boards on the wards we visited which provided feedback to patients and others who had raised concerns.

Emotional support

- Two counsellors and one social worker were employed across the Trust. At WHH a need was identified from carers who needed ongoing support and a monthly carer's support group was facilitated. We were told that feedback from the carers was very positive.
- There was a cancer survivors' forum facilitated for patients given a limited prognosis. Group support was considered a large part of the care provided to patients and carers.
- The SPC team, including the counsellors and social worker, linked closely with the local hospices. This enabled them to signpost patients towards community support from hospital. These included bereavement counselling and groups as well as local site specific tumour groups.
- We saw examples of Trust leaflets such as "Help for the Bereaved" that were available for families and provided information and guidance.
- The Chapel was available for all patients, visitors and staff. We saw facilities for Christians as well as what was required for Muslim prayers, including washing facilities. There were links with all the main faiths in the areas and a clear philosophy to support all people of any faith or no faith. There were information leaflets on the service provided, bereavement, death of a child and support groups.
- There was one Chaplain and 16 lay chaplains who were linked to specific wards, building strong relationships with the staff.
- The Chaplaincy supported bereaved families and staff and conducted funerals when requested.
- We saw that prayers had been collected from patients on the wards.
- The viewing room in the mortuary did not have religious symbols but there was a cross available should this be required. Staff demonstrated full understanding of other religions and cultures and worked hard to accommodate and facilitate practices as and when requested. We were told that Muslim families generally prepare the body and that this was supported both by ward and mortuary staff.

Are end of life care services responsive?

Requires improvement

The specialist palliative care team were easily accessed by a referral form and responded in a timely manner. Individual, holistic care was provided to end of life care patients with complex symptoms and needs. The team were not resourced to support the less complex end of life care patients. Development and improvement work was underway in line with the East Kent regional work.

Staff worked to address issues and concerns promptly and the small number of formal complaints were monitored and actioned.

Service planning and delivery to meet the needs of local people

- The SPC team were described by all staff we spoke with as professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals to, for example, therapists. Referred patients were entered on the trust system as end of life care.
- Patients with the most complex needs were referred to the SPC team. However, the SPC team acknowledged

that they did not have sufficient resources to support generalist staff to have the skills and confidence to care for patients at the end of life with less complex needs. This also impacted on audit and quality measurement.
- The palliative care team and the End of Life Care Steering Group worked closely with the East Kent CCGs to ensure service provision that will meet the needs of local people. However, much of this work was embryonic and under development at the time of the inspection visit.
- Where the preferred place of death was known staff endeavoured to facilitate this. The trust did not collect information on whether patients died in their preferred place.
- In addition, rapid discharge for patients who wished to die at home was sometimes delayed and therefore did not always happen. We were told that this was sometimes due to hospital processes and sometimes to external delays with funding and care packages for complex needs. An audit of discharge home to die was proposed.
- The mortuary staff at the William Harvey Hospital undertook a daily track of the mortuary spaces available for the three hospitals.
- The mortuary had fridges that could accommodate bariatric bodies. The recent installation of an overhead hoist system meant that bariatric bodies could be transferred more easily.
- There were concerns raised regarding forward planning for the impact of winter with increased admissions and deaths at that time of year.

Meeting people's individual needs

- Once a patient was referred to the palliative care team there was a plan for treatment and care in place that took account of each patient's individual needs. This could be working in conjunction with other specialist nurses to support patients with complex symptoms as well as those with complex needs being cared for by generalist teams.
- The SPC team and other nursing staff we spoke with told us that all communication would include the patient and those people who were important to them. We saw evidence of discussions and planning in the patient records we reviewed.
- Once a patient was for end of life care there was open visiting for families and they could sleep in the side room on a mattress if they wished.
- Telephone translation services were available where required.
- We saw examples of end of life care patients also living with dementia where staff demonstrated an understanding of best interest meetings where a patient lacked capacity to make decisions for themselves.
- The Chaplaincy staff were available to support patients, relatives and staff when called upon and in a manner according to each individual person's needs. For example, they conducted weddings for patients at the end of life if requested. Staff referred patients to the service.
- The relative support service facilitated people's wishes after the death of a relative.

Access and flow

- Access to the palliative care team was by referral form. Records we looked at showed that the team visited patients generally within 24 hours as many patients were referred in the last days of life.
- We attended the weekly multidisciplinary meeting across the three acute hospitals and heard that there was good access to the hospices. However, there were some delays for patients requiring fast track discharge. We were told that this was not working so further work was planned to try and improve the service.
- We heard and observed that the meetings were very productive.
- The Relative Support Office was open from 10am to 4pm Monday to Friday. The RSO booked all appointments for families following a death, liaised with funeral directors and ensured that the medical records and all documentation was in place for the doctors to complete the MCCDs. They also saw anyone who had a query or a concern.
- Families attending for appointments were escorted to a quiet room for discussion, advice and information. Patient belongings were stored there.
- We observed two telephone calls whilst in the office. One was arranging a meeting with relatives and providing initial advice and information. The other was responding to a specific request from a family.
- The Chaplain was available on site from 9am to 5pm Monday to Friday. An on-call service was provided for out of hours. If the Chaplain was not in the office there was a telephone number to call in hours. However,

when we tried the number it was faulty and cut off. We were told that this was a long standing issue of intermittent failures that they had raised within the hospital.
- There were 50 spaces in the mortuary fridges, ten spaces of which were wider to accommodate bariatric bodies.
- Foetuses less than 16 weeks were prepared for cremation once a month.
- We saw the daily tracking system in place regarding mortuary spaces across the three hospitals (WHH, KCH and QEQM) that was coordinated by WHH mortuary staff. This ensured that arrangements could be made for requesting extra spaces if this was required.
- A daily list for post mortems was prepared and the bodies placed in the fridges that had doors at both ends to facilitate transfer into the post mortem room.

Learning from complaints and concerns

- The patient experience department was restructured 18 months ago and also included Patient Advocate and Liaison Service (PALS) and the Relative Support Officers (RSO).
- Should a query or concern be raised the person would be directed to the RSO office in the first instance. PALS staff supported when required and would liaise with the ward, nursing staff or consultant as appropriate. All efforts were made to resolve issues as quickly as possible for patients and their relatives.
- Out of hours there were complaint forms that could be completed and a telephone number to leave a voicemail. The hospital web site also provided anyone with the opportunity to make a comment, raise a concern or make a formal complaint.
- All contacts were logged on an electronic system including queries and advice, concerns and formal complaints.
- Staff felt the structure was an improvement and the team worked well together.
- The end of life care and palliative care service did not receive a high number of complaints. We were provided with the complaints log for the period April 2014 to March 2015. There were a total of 16 complaints of which eight concerned WHH. Three of the eight complaints were not upheld following investigation. The issues were raised in different areas of the hospital and there were no obvious themes identified.

Are end of life care services well-led?

Requires improvement

The trust worked in line with the East Kent CCGs' end of life care strategy. This was developing. Since the last inspection there remained a lack of Trust Board direction for end of life care. There remained a non-unified approach across the wards and departments.

We found improvements in governance arrangements, staff communication and the culture within the trust.

There remained concerns that the specialist palliative care service was sustainable and that the proposed improvements could not be implemented without further resources.

Vision and strategy for this service

- End of life care (EOLC) sits in the Specialist Services Division and there was a Trust-wide End of Life Care Board that met bi-monthly. The Consultant Nurse for Palliative Care attended this board. The four East Kent Clinical Commissioning Groups (CCGs) had an end of life work stream group and was setting the EOLC strategy for the area. The Consultant Nurse for Palliative Care attended the East Kent CCG work stream in order to feed back into the EOLC Board at the Trust. The strategy had been circulated prior to the 25 June 2015 EOLC Board. The trust will then develop their strategy in line with the CCG strategy.
- The East Kent End of Life Strategy was in final draft form. The strategy stated a commitment to improving the end of life experience for patients and their relatives and that this involved all parties working closely together. It considered the expected increase in demand for both cancer and non-cancer end of life care in the region.
- We were provided with a copy of the East Kent draft improvement plan based on the NICE quality standard for end of life care. The leads and timescales were not yet completed on the document.
- We were provided with a copy of the trust-wide 'End of Life Work Plan 15/16' that included raising staff awareness, training and education, audit and development of personalised care plans for end of life.
- There was as yet no replacement for the Liverpool Care Pathway that was phased out from July 2013.

End of life care

- In the absence of a national pathway, there was continued work underway to develop trust wide personalised care plan documentation to support the use of the five priorities for care following the discontinuation of the Liverpool Care Pathway (LCP). This was based on current evidence and staff had obtained other NHS trust versions for consideration. This work would be rolled out by the palliative care link nurses.

Governance, risk management and quality measurement

- There had been considerable work done to improve communication between the board and the ward. We were told the EOL Board now has matron support for end of life care as a priority.
- The EOL Board minutes fed into the Patient Safety Board and into the Specialist Palliative Care meetings for decision making and implementation.
- We were told that the Specialist Palliative Care Teams oversaw the whole end of life care agenda trust-wide. Staff said that for implementation additional resources would be required.
- There was no contract or service level agreement in place between the trust and the local hospice.
- There was a trust wide Hospital Palliative Care Team Annual Report for 2013-2014 that described the staffing, role and training provided by the team. We were told that the information for the 2014-2015 report had not yet been collated.
- We were told that staff would like to undertake more audit and quality monitoring. However, with the current resources this was not possible. They wanted to audit knowledge of the five priorities of end of life care as they were aware that these were not embedded everywhere in the hospital.
- An EOLC conversation form was introduced to ensure conversations and good communication was maintained with patients and their families. An audit of use of the forms showed that there was limited take up of the forms with variable understanding and knowledge on the wards. Further work was underway to raise awareness and a re-audit proposed.

Leadership of service

- The Medical Director was the nominated lead for end of life care at Trust Board level.
- At the last inspection in March 2014, we noted that there was a lack of Trust Board direction and that this was evident in a non-unified approach to end of life care across the wards and departments. We have found the same lack of direction and non-unified approach at this inspection.
- Individual staff, both clinical and non-clinical, were passionate and committed to delivering quality care to patients and their families at this difficult time. However this was still frequently managed in an ad hoc and reactive manner as need was recognised. The early identification and resourcing referred to in the draft East Kent End of Life Care Strategy were not in place.
- The consultant orthogeriatricians took a lead on supporting end of life care on the hospital's trauma and orthopaedic wards. They described ongoing collaborative work with the CCGs and nursing homes in the region. These included work on a frailty pathway, anticipatory care plans (PEACE) and shared governance meetings with the CCGs.
- The leadership and team working within the palliative care team was of a high standard and this was confirmed by all staff we spoke with.
- The Trust closely monitored times to issue of the Medical Certificates of Cause of Death (MCCD) across the three acute hospital sites and demonstrated awareness of the causes of any delays. One cause cited was the winter pressures period due to the increased volume of admissions and deaths. This was confirmed by patient experience staff we spoke with. They were responsible for supporting the process in ensuring that the patient records and all necessary forms and documentation were available for the medical staff completing the certificates. Despite this being a known annual occurrence we did not find evidence of forward planning to mitigate the impact to reduce delays and provide resources and support for staff. We were told that this had been raised with management following significant difficulties during last winter.
- An external company was contracted to provide the portering service. We were told of good working relationships between the company and the Trust management. However, despite staff reporting difficulties with the newly changed Last Rights process and new equipment for transferring the deceased from the ward, there did not appear to be effective joint management to increase staff understanding, confidence and competence. This impacted on the

deceased's dignity being protected at all times and on staff welfare as non-clinical staff were witnessing more than they expected or were trained for. All staff were distressed when dignity was compromised.
- The new processes and equipment were purchased in response to health and safety concerns regarding manual handling as well as to reduce the possibility of damage to deceased people. However, there was a lack of consultation, education and information provided to staff in advance of implementing the changes.

Culture within the service

- All staff we spoke with described an improving culture since the interim Chief Executive Officer and other changes in the senior management team had taken place. These were quite recent but staff already felt an impact in a drive to be a more open organisation. They also felt that communication had improved.
- Consultants we spoke with felt more able to engage with senior management recently.
- There remained areas where staff felt change was not occurring but they understood that change does not happen quickly when involving culture and behaviours.
- We heard from staff that the buddy system in place was helpful, as was the external counselling service provided by the Trust.
- We heard varied comments regarding processes such as the incident reporting system. Some staff felt that it was a good learning process. Some felt it was used to point out errors in other departments but was not used to self-report in the same way.

Public and staff engagement

- The end of life care service had not undertaken a patient, relative or carer survey at this hospital.
- However, Critical Care had undertaken a survey of 14 bereaved relatives in 2014. The results were all either excellent or good for: privacy, dignity, pain control, hygiene, patient comfort and information provision. Comments included, "Staff were professional and often went the extra mile to make you feel [relative] was a person, not just another patient;" The consultant on duty was outstanding … communication is an art."
- The 'In my shoes' project was a trust initiative that involved patients/relatives giving an account of their experience of being treated in the trust.
- Staff spoke highly of the Quality Improvement and Innovation Hub. This was an area where staff could come with suggestions for improvement. There was an end of life care stand that included a recording by a relative of a deceased patient talking about what went wrong with their end of life care. It was manned once a week from 8am to 6pm and staff told us that many ideas were generated. We saw trust responses to issues raised.

Innovation, improvement and sustainability

- Some of the reviews that were underway at the previous inspection in March 2014 had been completed, including the 'amber care bundles' pilot on the renal ward. No decisions had yet been made as to what tools and documentation would be put in place.
- The reduced specialist palliative care resources mean that this service remained unsustainable and will not be in a position to implement the end of life improvement plan and strategy when they are finalised.
- There was considerable reliance on IT systems for e-learning, cascading information and, for example, the incident reporting system. Staff described ongoing difficulties with the systems that included being very slow, closing down and sometimes not allowing access. These difficulties caused a lot of wasted time for staff as well as considerable frustration when busy. One example given was that completed e-learning was not saved by the system and it therefore appeared that the member of staff had not done the training. The impact affected staff salary levels. Staff did not appear to know whether this would be improved.
- The implementation of the Medical Interoperability Gateway (MiG) system that enabled the trust to view, with consent, patients' GP records meant that this information was available 24/7. We were informed that version 2 was due later this year and would allow patients' care plans to be viewed and updated. Other local healthcare providers such as the ambulance service will also be able to view the patient records. This will mean that ambulance staff would be aware if a patient was on an end of life care pathway prior to bringing the patient into A&E.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services are held across the trust at six locations. We visited five of these locations during our inspection: William Harvey Hospital (WHH), Queen Elizabeth, The Queen Mother Hospital (QEQM), Kent and Canterbury Hospital (KCH), Royal Victoria Hospital and Buckland Hospital. The centralized outpatient appointment center was located at Kent and Canterbury Hospital. Health Records departments were located at each site.

In the last calendar year the trust saw 1,060,985 patients in their outpatients departments 294,780 of these appointments were at WHH. Of these appointments 59% were follow up appointments, 33% were first appointments, 7% were appointments that patients did not attend, and 1% were cancelled by the patient.

Outpatients services were undergoing an improvement strategy which included the reduction of the number of facilities used for out-patient clinics from 15 to six; WHH Ashford, KCH Canterbury, QEQM, Margate, RVH Folkestone, Buckland Hospital Dover and Estuary View Medical Centre. At the time of our inspection Buckland hospital had recently opened. Estuary View opened on the week of our inspection so on this occasion we did not inspect this site.

WHH had a main outpatients located on the ground floor which was divided into four areas Area A, B,C and D. There was also a newly built procedure suite which was managed by main outpatients. The hospital had a fracture clinic and orthopaedic clinic run by the surgical division which we visited during our inspection.

The trust offered outpatient appointments for all of its specialties when assessment, treatment, monitoring, and follow-up were required. There were clinics for general surgery, respiratory, medicine, neurology, dermatology, diabetes, pain, vascular, gastroenterology, women's health, and health care of older people.

The radiology services at this site provide general x-ray, MRI, CT, obstetric and general ultrasound to the local population. In the year 2014/15 the department performed 204,973 examinations and scanned 224,962 body parts. During our inspection, we visited the diagnostic imaging department and spoke with 14 members of staff.

At the time of inspection, we spoke with twelve patients and 46 members of staff in total. These staff included reception and booking staff, clerical and secretarial staff, nurses of all grades, radiography staff, doctors, and consultants. We observed care and treatment. We reviewed performance information about the department and Trust.

Outpatients and diagnostic imaging

Summary of findings

The outpatient and diagnostic imaging department was well led and had improved since implementing an outpatient improvement strategy. Despite the strategy being relatively new, through structured audit and review the department was able to evidence improvements in health records management, call centre management, referral to treatment processes, increased opening hours, clinic capacity and improved patient experience.

Although there was still improvement required in referral to treatment pathways the outpatients department and trust demonstrated a commitment to continuing to improve the service long term.

As a part of the strategy the trust had pulled its outpatient services from fifteen locations to six. We inspected five of these locations during our visit.

Managers and staff working in the department understood the strategy and there was a real sense that staff were proud of the improvements that had been made. Progress with the strategy was monitored during weekly strategy meetings with the senior team and fed down to department staff through staff meetings and bulletins.

Outpatient and diagnostic imaging departments at the William Harvey Hospital were providing safe care to patients. There were systems in place, supported by adequate resources to enable the department to provide good quality care to patients attending for appointments.

Evidence based assessment, care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines by appropriately trained and qualified staff.

A multi-disciplinary team approach was evident across all the services provided from the outpatients and diagnostic imaging department. We observed a shared responsibility for care and treatment delivery. Staff were trained and assessed as competent before using new equipment or performing aspects of their roles.

We saw caring and compassionate care delivered by all staff working in the outpatient and diagnostic imaging departments. We observed throughout the departments that staff treated patients, relatives and visitors in a respectful manner.

Nurse management and nursing care was particularly good. Nurses were well informed, competent and went the extra mile to improve patient's journey through their department. Nurses and receptionists followed a 'Meet and Greet' protocol to ensure that patients received a consistently high level of communication and service from staff in the department.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

Outpatient and diagnostic imaging departments at William Harvey Hospital were providing safe care to patients. There were systems in place, supported by adequate resources to enable the department to provide good quality care to patients attending for appointments. We spoke with staff of all grades and disciplines across the outpatient areas and were told that the majority felt the department was adequately staffed to meet patients' needs.

We found that the environment was safe and the required safety checks were being completed and recorded. The department was clean and well maintained. Equipment was readily available and staff were trained to use it safely. Hand gel dispensers were in situ at the entrances of the outpatient clinics along with other areas of the clinics. Although the clinics were busy, nursing staff provided good and safe care to patients. Treatment records were informative and showed a clear pathway of the care and treatment patients received at the hospital.

Health records management had been addressed as a part of the outpatients' improvement plan. We observed clear systems in place in the department which ensured that management of health records was duplicated across all outpatient locations. As a consequence audit results showed that on average the trust had 98.7% of health records available for patient outpatient appointments

Incidents

- During the last year there had been one serious incident reported in outpatients between May 2014 and June 2015 concerning an appointment delay. There had been one serious incident reported in histopathology during the same period. There had been no Never Events reported for the same period for both outpatients and the diagnostic imaging department. We were told that all incidents were investigated and were given evidence of that including action plans and learning from incidents.
- The matron told us they received regular reports of incidents and this enabled them to identify themes and trends and take corrective actions accordingly.
- Incidents were reported as per trust policy via an electronic incident reporting system. They were reviewed at the clinical risk meeting and clinical governance meetings, and also at departmental level. Incidents were also documented in the annual clinical governance report.
- Nursing staff informed us they were encouraged to report incidents which occurred in their working area. All of the staff we spoke with were confident to report incidents via the trusts electronic reporting system.
- We were given examples of incidents which had been reported by various outpatient clinics and diagnostic and imaging departments, staff were able to inform us of the changes which had happened as a result of their report.
- Matron wrote a monthly report for staff outlining what incidents had been reported and any mitigation that had been put in place as a result. Staff understood that incidents were monitored, and felt that they consistently received feedback on the outcomes and action taken as a result of their report. We were shown evidence of learning as a result of an incident reported and investigated by the department.
- We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns in a timely manner.
- The matron demonstrated knowledge of duty of candour and their responsibilities around this.
- We spoke with diagnostic imaging staff who reported they were happy with the incident reporting process. They reported incidents as per trust policy via an electronic system. This system automatically sent feedback to the staff member raising the incident.

Cleanliness, infection control and hygiene

- The overwhelming majority of staff we observed in the outpatient clinics and diagnostic imaging department were complying with the trust policies and guidance on the use of personal protective equipment (PPE) and were seen to be bare below the elbow. However, on the day of our inspection we observed the doctors treating patients in treatment rooms 24, 29 and 31 were not bare below the elbows. It is essential for good hand hygiene practice and to prevent the spread of infection that staff are bare below the elbows.

Outpatients and diagnostic imaging

- We observed staff in the outpatient clinics undertaking hand washing when attending patients and in-between patients. Staff working in the outpatient clinics had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.
- The clinic areas and imaging department were visibly clean and tidy. We saw staff cleaning the areas between use by patients using appropriate wipes, thus reducing the risk of cross-infection or cross-contamination between patients. Within the imaging department staff took active measures to ensure that infection control issues were appropriately dealt with.
- Toilet facilities were located throughout the outpatient and diagnostic imaging departments and these were clearly signposted. We looked at a sample of these and saw they were regularly cleaned with records showing when they were last cleaned. Clinical areas were monitored for cleanliness by the facilities team. Housekeeping staff could be called to carry out additional cleaning, where staff felt it was necessary.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place in each clinic room and observed that these had been completed to provide assurance that equipment and rooms had been cleaned. The equipment that we saw was in good repair we noted that green labels were placed on the equipment that had been cleaned.
- The department audited sharps bins monthly to ensure that they complied with best practice. Where issues were raised during audit they would be dealt with directly by the nurse managing the audit.
- We checked six sharps boxes and all six were labelled as they should be with the start date and the signature of the member of staff that had assembled the box. We were told that sharps boxes were removed when they were 75% full or three months old. We saw none that were over filled and all were within this date range.

Environment and equipment

- We found that, the outpatient and diagnostic imaging department had resuscitation equipment, with appropriate signage directing staff to its location. All resuscitation equipment was checked during our inspection and found to contain automated external defibrillator, suction equipment, and oxygen along with the appropriate emergency drug and medical supplies. Other equipment was visibly clean, regularly checked and ready for use.
- Audits of resuscitation trollies were completed monthly across outpatients and radiology. Review of these audits evidenced that staff took mitigating action where they found issues during these audits.
- The medical physics department provided the radiation protection service to all of the East Kent Hospitals and this incorporated the annual equipment checks. An environmental agency visit for regulatory checks of the environmental permitting regulations had been completed in the last six months. We observed that there were no outstanding recommendations from this.
- In diagnostic imaging, quality assurance checks were in place for equipment. We saw examples of recent audits for medical devices and quality management systems certification. These were mandatory checks required by the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000).
- Access to both MRI and CT department examination rooms were controlled by fob locks which prevented unauthorised entry.
- From observation in the outpatient clinic we saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment that was needed at the clinic.
- The trust had recently changed its management of equipment and staff now accessed equipment through an equipment library. Staff told us that although there had been some initial teething problems the service worked well and they were able to access equipment when it was required.
- Equipment was maintained, checked regularly and given a portable appliance test (PAT) in line with the trust's policy. Labels on equipment stated when the equipment was last checked. All equipment we saw had been checked within the last year.
- The matron and sister completed a monthly environmental audit where they inspected the outpatient's environment for suitability and cleanliness. Areas were RAG rated and either given a pass or fail mark. Where areas had failed this audit action plans were in place to drive improvement.

Outpatients and diagnostic imaging

- Main Outpatients audited the number of maintenance requests that had been addressed by the estates team with seven working days. Between March 2014 and April 2015 100% of maintenance requests had been completed within seven days against a target of 80%.
- The main outpatients area is divided into four waiting areas: A, B, C and D. The patients arrived at the main outpatient's reception and were guided to the correct waiting area for their clinic appointment.
- There was a newly built procedure suite which was managed by main outpatients. The hospital also had a fracture clinic and orthopaedic clinic run by the surgical division which we visited during our inspection.
- We inspected ten pieces of medical equipment across the range of consulting rooms that were available to be entered. We were told that each piece of medical equipment was serviced each year. Eight pieces of equipment were date stamped within the time frame. The two that were not had not reached their first anniversary and we saw evidence that these pieces of equipment had been purchased in the last 12 months therefore they were not yet requiring a service.
- The staff told us that since the equipment library had been set up getting equipment delivered to the specific clinic was an easy process. We were told there was a dedicated equipment library porter who they would call and ask for a specific piece of equipment dependent on the clinic. We were told that since the library had been running the porter had got so used to which clinics run and when that they arrived with the equipment before staff had to ask for it.
- Within the OPD there was a dedicated band 6 nurse who was responsible for the training records and competency checks for the staff training on medical devices and equipment. We saw five staff records taken at random from the training file. All training was recorded and in date. There were also the further signature of the band 6 nurse to show she had checked the competency of the member of staff on all of the devices that were pertinent to the grade of staff and which area they worked within. All staff had received training on couches and blood pressure machines.

Medicines

- Medicines were stored in locked cupboards in the outpatients and diagnostic imaging departments. Nursing staff ordered all medicines through the hospital pharmacy. Pharmacy monitored stock levels once a week. Nurses told us that the level of support that they received from pharmacy was satisfactory.
- A lockable medicines fridge was in place, and daily temperature checks were recorded. Temperature records that we looked at were completed and contained minimum and maximum temperatures to alert staff when they were not within the required range. We also found evidence of prompt and appropriate action that had been taken when the fridge had been found to be outside the recommended temperature range.
- The ambient room temperature was also monitored in the room where medications were stored. This ensured the efficacy of the medications. We found the medications stored in the department were within their expiry date and stored securely.
- Prescription pads were stored in a locked cabinet. When clinicians wrote patient prescriptions the clinic kept a log which identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.
- Rigorous checking procedures had alerted staff quickly where a prescription pad had gone missing. Staff demonstrated that they had followed correct procedures where this had occurred.
- Outpatients audited prescription pads monthly to ensure that processes were being followed. Audit results showed 100% compliance.
- Outpatients audited prescription pads monthly to ensure that processes were being followed. Audit results showed 100% compliance.

Records

- All staff reported a marked improvement in the availability and quality of patient health records. Following our last inspection where this had been highlighted as a problem within the department the trust had rolled out a 'Your Responsibility' campaign. The campaign targeted all staff and made them responsible for looking after, correcting errors and tracking notes to the right departments.
- Staff within the health records departments were very proud of what they had achieved since our last inspection. The departments were fast paced but calm and organised. Staff were able to work at short notice where needed to source health records for clinic. They

spoke about their sense of achievement when they managed this when time was against them. They told us that they worked well in their teams and supported each other when it got busy.

- Between May 2014 and April 2015 audit results showed that on average the trust had 98.7% of health records available for patient outpatient appointments. This figure excluded availability for short notice clinics. The trust had a target for availability of health records set at 98%. They had met or exceeded this target for every month in that period.
- The latest audits of health records which covered the three month period of April, May and June 2015 showed that over this three month period health records had supplied 5588 health records for clinics, with 174 of this total being temporary records.
- The department audited the reason why temporary notes had been used in clinic. Over this period 18 were set up because the appointment was at another site, 12 had been requested but not sent, 29 already had a temporary set of notes which were used again, and 46 were for late appointments (less than 48hr notice).
- The Health record management team managed the health records for all the hospitals in the trust. They used identical systems in each hospital. They had a dedicated van that made two trips to each location including the off-site facility every day. We asked what happened if there were too many notes for the van to take and we were told that they were then sent by taxi if needed before the van made its second trip . On the day of our inspection we were told that funding had just been given for a second van. We asked if operation stack (where lorries were parked on the M20, effectively closing the motorway) had any effect on delivery times. We were told the drivers always seemed to be able to find other routes.
- The trust had a Health Records manager responsible for health records trust wide and then three site leads that covered the individual sites.
- The Health Records team does all the picking and tracking out of all notes. They initially get the clinic list eight days before a clinic where they can pick the notes, highlight any missing, notes that are in other clinics and start searching for missing notes. The staff then pick any further notes three days before and highlight notes still missing. They will start to make temporary files based on the clinic the patient is attending and what information they have in the way of results and letters. Within 24 hours they will revisit to see if they can complete the list of notes, if they can't then the temporary set is used.
- If these notes were off the site the trust had a facility to scan the notes 24 hours a day and within 15 minutes the person requesting could read the notes. They had a system whereby temporary notes were highlighted on the system and when the originals were found they were merged and duplicates destroyed.
- The department were in the process of procuring another off-site storage facility which would store inactive notes. These were notes that have not been used for two years.
- The radiology department was using a Picture Archiving Communications System (PACS) for the storage of examinations and their results. We observed that each member of staff had their own unique password for this system.

Safeguarding

- Staff we spoke with were aware of their responsibilities and understood their role in protecting children and vulnerable adults. They demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. The trust had a whistleblowing and safeguarding policy that was known to staff working in the outpatient and diagnostic imaging department. They told us that they would feel happy using this policy to raise concerns if they felt it was necessary.
- There was a safeguarding lead at the hospital and the outpatient and diagnostic imaging staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the Trust's safeguarding lead was and how to contact them.
- Each outpatient site had a safeguarding link nurse. The link nurse had a special interest in safeguarding and attended regular meetings to ensure they were updated with the most recent best practice guidance. They shared their learning with the rest of their team and operated as a resource for the department where questions around safeguarding decisions were made.
- Staff in the outpatient and diagnostic imaging department had completed mandatory safeguarding training to level 3, and child protection level 3 training. They were able to talk to us about the insight and

knowledge gained from this training. An outpatient's staff nurse was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.

Mandatory training

- Staff told us they were given time to undertake mandatory training which was offered in a format of e-learning with some face to face training for training such as manual handling. Staff in the radiology department told us it was a challenge to complete all the mandatory training due to time pressures and the availability of computers.
- Staff knew how their training was monitored and confirmed that managers reminded them when training was overdue and needed to be completed.
- We saw examples of staff training records showing completed training. We also saw examples of the monitoring that showed that staff had undertaken all mandatory training, such as health and safety, infection prevention and control, moving and handling, safeguarding and basic life support.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.
- Across all staff groups including both clinical and administration staff the percentage of outpatients staff who had had completed mandatory training was Equality and Diversity 92.5%, Fire Safety 90.1%, Health and Safety 77.5%, Infection Control 88.6%, Information Governance 82.5%, Moving and Handling 92.2% and Safeguarding 93.2%.
- Across all staff groups including both clinical and administration staff the percentage of radiology staff who had had completed mandatory training was Equality and Diversity 84.2%, Fire Safety 76.0, Health and Safety 78.4%, Infection Control 81.3%, Information Governance 63.0%, Moving and Handling 81.3% and Safeguarding 64.8%.
- Across all staff groups including both clinical and administration staff the percentage of pathology staff who had had completed mandatory training was Equality and Diversity 88.3%, Fire Safety 80.8%, Health and Safety 74.9%, Infection Control 83.0%, Information Governance 77.1%, Moving and Handling 84.7% and Safeguarding 84.3%.

Assessing and responding to patient risk

- The hospital had systems and processes in place for responding to patient risk. Staff were noted to be available in all the waiting areas of the clinics so that they would notice patients who appeared unwell and needed assistance. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia or learning disability, and elderly or frail patients with more than one medical condition.
- There were clear procedures in place for the care of patients who became unwell. Staff we spoke with told us about the emergency procedures and escalation process for unwell patients. However they stated these had not been used often as the department did not often have acutely unwell patients.
- There were emergency assistance call bells in all patient areas including consultation rooms, treatment rooms and the x- ray suite. Staff we spoke with told us when the call bells were used they were answered immediately. Staff we spoke with were aware of their role in a medical emergency. Staff provided an example of a patient who had become acutely unwell during a clinic appointment where a cardio-respiratory resuscitation (CPR) team had been called to assist the patient.

Nursing staffing

- The outpatient clinics were staffed by registered nurses and health care assistants. Each clinic was run by registered nurses and was supported by health care assistants.
- Where areas required a trained nurse to be available for clinics, for example breast clinics, they would be provided.
- Doctors that we spoke with told us that they were able to be supported by chaperones where required.
- The main outpatients was working with almost a full complement of staff and had only one Band 2 vacancy. The department employed five registered nurses, 17 Health care assistants, and one Band 4 Practitioner.

Medical staffing

- Medical staffing was provided by the relevant speciality running the clinics in the outpatient department. Medical staff were of mixed grades, from consultants to junior doctors. There was always a consultant to oversee the clinics, and junior doctors felt supported by the consultants.

Outpatients and diagnostic imaging

- Doctors we spoke with thought they had a good relationship with outpatient nursing and clerical staff. They said they felt well supported and could discuss issues with them.
- Staff in the diagnostic imaging services told us that staffing levels had significantly improved over the last 18 months and that the department was almost up to full staffing levels. Despite this, we were informed that there were often delays in the recruitment process which resulted in staff being 'lost' during the process. Staff told us that they considered this to a waste of resources and was demoralising.
- The trust's annual leave policy stated that medical staff must give eight weeks' notice of any leave in order that clinics could be adjusted in a timely manner. The outpatient department audited compliance with this policy. Where doctors had not followed the policy staff escalated this to divisional leads to be investigated.
- Consultants and registrars provided cover for each other at times of annual leave or sickness whenever possible. All medical staff we spoke with confirmed that cancellation of a clinic was a last resort.
- Where data in the main outpatients departments indicated that clinic templates were not meeting with patient demand, for example clinics that were consistently overrunning, matron used this data to discuss changing the templates to reflect this demand with divisional leads and consultants.
- Matron in main outpatients produced an annual survey for consultants and doctors asking how they felt about the service and any service improvements they felt could be made. In this year's survey they had included questions about working out of normal clinic hours in order to get a gauge on which consultants may be prepared to manage clinics outside of outpatient hours.
- The results of the 2015 consultants' survey showed that 124 consultants responded to the survey trust wide. 98.3% were satisfied with Nursing support in the department, 95.1% were satisfied with nursing investigations prior to clinic, 67.4% were satisfied with their clinic template, with 42.7% being prepared to work extended hours to assist with capacity issues such as overbooking of clinic templates.

Major incident awareness and training

- The trust had a business continuity management plan which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as winter pressures, fire safety, loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.
- Most staff we spoke with were aware of the hospital's major incident plan such as winter pressures and fire safety incidents, and they understood what actions to take in the event of an incident such as a fire. The matron and sister demonstrated an in-depth knowledge of this plan and how they would implement it.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence based assessment, care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines by appropriately trained and qualified staff.

A multi-disciplinary team approach was evident across all the services provided from the outpatients and diagnostic imaging department. We observed a shared responsibility for care and treatment delivery. We observed patients received effective care and treatment in line with national guidelines. Patients were provided with sufficient information about their treatments and had the opportunity to discuss any concerns. WHH ran a one stop clinic for dermatology and urgent skin cancers, rheumatology, cardiology and vascular clinics. Other one stop clinics ran across other outpatient locations in the Trust. Outpatient managers were working with divisions to increase the numbers of one stop clinics as part of the outpatients' strategy.

Staff working in the clinic told us their managers encouraged their professional development and supported

them to complete training. Appraisals were undertaken annually. Nursing staff completed competency assessments which related to the work that they undertook in each clinic area.

We saw evidence from staff training records that clinical staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff undertaking procedures were aware of the need to obtain patients' consent and completed appropriate consent documentation.

Diagnostic imaging staff were meeting the requirements with Ionising Radiation regulations 1999, IR(ME)R regulations 2000 and have regular environmental health audits.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance and the trust's treatment protocols and guidelines were available on the Trust's intranet. Staff told us that guidance was easily accessible and was clear and comprehensive. We saw that the outpatients and diagnostic imaging department was operating to NICE guidance, Royal College of Radiology, local protocols and procedures. Staff we spoke with were aware of how this guidance had an impact on the care they delivered.
- We noted that NICE guidelines were in use in most clinics. Staff we spoke with described how they ensured that the care they provided was in line with best practice and national guidance. Adherence with NICE guidelines was monitored by the relevant directorates' clinical governance committees.
- NICE guidance for smoking cessation had been met within the department. The outpatients assessed each patient who accessed the service to establish whether they would benefit from a referral to the smoking cessation service. Staff would refer patients to the service where a need was established. These assessments had recently been updated to include the use of E cigarettes.
- Main outpatients audited the number of patients who had been assessed for their smoking status and offered advice. Between March 2014 and April 2015 90.3% of patients had been offered this service against a target of 100%.
- Staff in the department demonstrated a working knowledge of NICE Guidance for recognising and responding to acute illness in adults in hospital. The department used a multiple parameter scoring system to allow a graded response to patients who became unwell in the department.

Pain relief

- The imaging department had a stock of pain relief and local anaesthetic for use when invasive procedures were carried out. We saw that pain relief was discussed with patients during their consultation or treatment and analgesia was prescribed as necessary and dispensed by the hospital pharmacy.
- Patients at the outpatients department had access to pain relief when it was needed. Clinical staff reported that patients' pain was assessed and monitored to ensure they received the appropriate amount of pain relief when in clinic. Staff told us that they could give paracetamol to patients if they were in pain, but all other analgesics had to be prescribed before being administered to patients.
- Staff in the pain clinic told us prescribed pain relief was monitored for efficacy and where necessary changed to meet patients' needs. This was discussed with patients as part of their ongoing management of pain.
- Pain clinics were managed by specialist nurses and consultants. Following a 'We Care Survey' in the trust where pain relief was raised as an area for improvement the trust had completed some work around making improvements. Pain clinics were held at the three main outpatient sites (WH/QEQM/KCH). Patients were seen prior to their appointment where they were assisted to complete a pain scoring tool. This allowed patient outcomes to be monitored robustly.

Nutrition and Hydration

- We asked what provision was made for patients requiring a drink and also patients waiting longer than expected with regards to food provision. We were told and also witnessed staff offering drinks of water and flavoured squash. We were told that the patients that had waited longer than expected were offered a sandwich / snack from the friends shop, free of charge; this was confirmed by the staff who worked in the shop.

Competent staff

- Corporate induction training was provided for all staff and was compulsory for all staff to attend. There was also a service specific induction; this was specific to the

department staff worked in and their role. We saw records held within the outpatients and diagnostic imaging department which showed the induction records for new staff were comprehensive and up to date. All of the staff we spoke with confirmed that they had received their mandatory training in line with the Trust's policy.

- We spoke with a selection of staff in all departments who told us that they had participated in the annual trust appraisal system. All staff we spoke with told us they were well supported by colleagues and by their managers. 90.19% of nursing staff across outpatients were up to date with their annual appraisal.
- Staff throughout the main outpatients and diagnostic imaging departments were required to obtain competencies that were relevant to their role. Competencies were in place for clinical tasks, supporting patients, and use of equipment. Competencies included the knowledge and theory which supported the practice. We observed that the radiographers were registered with the Health Care Professions Council (HCPC) and this was checked annually. The department had an education lead that ensured that competencies were in place and up to date for all staff.
- Staff received mandatory training such as infection control, safeguarding and health and safety. They were also provided with training relevant to their specialty such as general surgery, orthopaedics or cardiology.
- We spoke with staff throughout outpatients who told us there were many development opportunities available for them and that the trust supported staff to broaden their competencies.
- We spoke with HCA's, sisters, link nurses, and nursing staff who described how the intranet published courses available and contained good information for them to access.
- Of the trust wide Band 4 training places offered to Band 2 nurses, four of the seven trust wide positions were given to Outpatient nurses. Matron was extremely proud of this as the feedback showed that the applicants were of a high standard. The band 4 training gave opportunities for nurses to tag on modules that were specific to their own working environment. Matron was ensuring that these modules would assist with the departmental plans to increase the numbers of one stop clinics across all outpatient sites.
- The matron was working alongside divisional leads to establish and train staff in competencies to improve pre-assessment clinics. This was where a patient was identified for surgery in an outpatient's clinic, a nurse would be able to take the patient through pre-assessment. This enabled the patient to be prepared for surgery in the same appointment and reducing the need for separate appointment in the hospital.
- Outpatient audited the checking process for trained nurses being updated with the nursing and midwifery council (NMC) registration requirements. They had a 100% target on these checks and had met this target each month over the period May 2014 to April 2015.

Multidisciplinary working

- WHH ran a one stop clinic for dermatology and urgent skin cancers, rheumatology, cardiology and vascular clinics. Other one stop clinics ran across other outpatient locations in the Trust. Outpatient managers were working with divisions to increase the numbers of one stop clinics as part of the outpatient's strategy.
- There was evidence of multidisciplinary working in the outpatients and diagnostic imaging departments. We were told about a number of examples of where joint clinics were provided e.g. breast clinic, dermatology clinic, ophthalmology, older person's clinic and oncology clinics.
- Many clinics had multi-disciplinary (MDT) meetings, particularly the cancer related specialties, where the team agreed and planned the care for patients and decided which clinician would be seeing the patient in clinic to explain the plan to them. We saw, for example, that a member of staff from the outpatient's clinic and breast radiology attended the breast care MDT. Additionally, the radiology teams within the Trust met for shared learning events every three months.
- Specialist nurses ran clinics for some specialties, such as a pain clinic, breast clinic, heart failure clinic and diabetic clinic. We spoke with some of the specialist nurses who described how their clinics fitted into patient treatment pathways. Nursing staff and healthcare assistants we spoke with in clinics, such as orthopaedic and gynaecology clinics, told us that teamwork and multidisciplinary working were effective and professional.

- We saw that patients were regularly referred to community-based services such as community nursing services and GP services.

Seven-day services

- As part of the public consultation process around the new outpatient strategy along with a need for managing capacity to meet with the increasing workload outpatients had recently increased its opening hours.
- Outpatients across all sites was now opened between 7.30am and 8pm Monday to Friday and on a Saturday morning.
- Two extra nurses had been employed on the three main sites (WHH,QEQM,KCH) and one extra nurse on the two smaller sites.
- Opening hours were supported by radiology, pharmacy, and therapy staff.
- Outpatients ran Monday to Friday from 8.30am to 5.30pm. We were told there were no evening or weekend clinics. The fracture and orthopaedic clinic provided Sunday service from 8:30 – 1pm.
- The diagnostic and imaging department offered seven-day services for inpatients and those who attended the emergency department. The diagnostic imaging department was open seven days a week from 8am to 8pm Monday to Friday and from 8am until 4pm Saturday and Sunday.

Access to information

- We found patient information leaflets throughout all areas of outpatients. The department was able to obtain leaflets in other languages and in large print format when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence from staff training records that clinical staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with confirmed they had completed training and undertaken regular updates. However we noted that their knowledge of MCA and DoLS was variable with some staff demonstrating clear knowledge of the act and its implications.
- Patients we spoke with said that they completed consent forms before their treatment, when this had been appropriate. We were told that clinicians asked for consent before commencing any examination and explained the procedure that was to take place. Staff undertaking procedures were aware of the need to obtain patients' consent and completed appropriate consent documentation. We saw good practices for consent within the dermatology clinics. The World Health Organization Surgical Safety Checklist (WHO) checklist had been adopted and used appropriately where invasive procedures were taking place.
- Where required mental capacity was assessed by consultants and doctors in clinic. Doctors had access to mental capacity assessments, best interest decision checklists, decision making flowcharts, and information on the process including a two stage capacity test.
- Outpatients had leaflets displayed in all outpatient areas which explained decisions around consent for patients. They explained the need for healthcare professionals to gain consent, forms of consent, and commonly asked questions around the consent processes.

Are outpatient and diagnostic imaging services caring?

Good

We saw caring and compassionate care delivered by all staff working at outpatients and diagnostic imaging departments. We observed throughout the outpatients department that staff treated patients, relatives and visitors in a respectful manner. Staff offered assistance without waiting to be asked.

Clinical room doors were kept closed and staff knocked before entering clinic rooms to maintain patients' privacy. However, there were some areas in the diagnostic imaging department where a patients privacy and dignity could be compromised.

Patients and relatives commented positively about the care provided to them by the staff from all the clinics visited. Staff ensured that patients understood what their appointment and treatment involved.

Patients told us they felt involved in their care and treatment, and they thought that staff supported them in making difficult decisions. Patients told us they were given sufficient information about their care and treatment and were fully involved in making decisions about their care

and treatment. All the patients we spoke with told us the staff were caring and polite. Patients we spoke with were satisfied with the services provided and stated that doctors and nurses had time to discuss with them their care and treatment.

Compassionate care

- We observed most staff interactions with patients as being friendly and welcoming. We observed some instances where patients that attended clinic regularly had built relationships with the staff that worked there. We saw examples of caring interactions by healthcare assistants. For example, friendly greetings getting down to a patient level to interact with them and maintaining eye contact.
- We saw that staff always knocked and waited for permission before entering clinic rooms. We also saw that clinic rooms had signage instructing people to knock and wait for an answer before entering to maintain people's dignity.
- In the diagnostic imaging department some staff raised issues regarding confidentiality in the x-ray viewing room as it was visible from the main corridor. During our visit we saw a retractable band across the entrance which did not prevent passers by in the corridor being able to see the screens and test results. Staff told us that a door at the entrance would ensure patient confidentiality.
- We observed issues regarding lack of privacy and dignity in the diagnostic imaging department. In the waiting area there was a screen provided but its size was too small and enabled patients to be visible. The ultrasound room had been divided into two rooms with the use of a curtain. The patients in the cubicles were in close proximity to each other and this compromised their privacy and dignity.
- One patient told us how the consultant had explained in detail their treatment options and ensured they had all the information they required. We observed a nurse explaining paperwork to a patient attending their first appointment, following a diagnosis of their illness. Everything was explained very calmly and they also ensured the patient and their partner had the correct phone numbers should they need to ring for more information.
- Patient's confidentiality was respected. Patients and staff told us there were always rooms available to speak to people privately and confidentially.
- Throughout the two days we visited the outpatient department, we observed nursing, healthcare and receptionist staff interacting in a positive and caring manner with patients. We saw that enquiries made at the reception desks were responded to in a polite and helpful manner. We saw patients being redirected to other clinic locations with a clear and reassuring approach.
- Reception staff told us when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at the desk. Patients waiting to be seen were signposted to stand back from the desk in order that conversations could be had in private.
- We witnessed patients being offered refreshments such as tea, coffee and water. We saw health care assistants informing patients of how long the wait was likely to be for their appointment and the reasons for this wait. We saw one nurse go to a patient specifically to talk in more detail. When asked why the nurse had done this we were told that the nurse knew the patient was hard of hearing and wanted to explain the wait on a one to one basis. We spoke with patients who had been sitting waiting for a clinic that was over running by between 15 minutes and 45 minutes. The patients that we spoke with were not concerned about the waiting time as they told us that they had been kept informed and felt that was important.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved and informed about their care. Patients told us they were given sufficient information to help them make any decisions they needed to make. We were told that treatment options were clearly explained.
- Staff were expected to use the departments 'Meet and Greet' protocol and competencies related to this protocol were assessed for all staff. This meant that patients were all treated with respect by staff and were kept informed of any clinic delays and the reasons for these. The department audited compliance with these competencies.
- Between May 2014 and April 2015 'Meet and Greet' competencies had been completed by 99.2% of reception staff and 99.71% of nursing staff. The Trust target for completion of these competencies was 90%. Both staff groups had exceeded this target every month.

Outpatients and diagnostic imaging

- Main outpatients gathered patient views and reported monthly on the findings. As a part of this survey patients were asked 'Did the doctor explain the reasons for any treatment or action in a way that you could understand?'. The response on this question in 2014 surveys was that 99% of patients felt that this was the case in the outpatients department.

Emotional support

- Staff explained how they tried to provide support to patients who were given distressing news. One nurse explained how they ensured they were with the patient when the consultant spoke with the patient. They would also make sure they stayed with the patient afterwards to ensure there was no delayed reaction.
- Patients and relatives we spoke with confirmed that they had been supported when they were given bad news about their condition. Staff explained how they ensured patients were in a suitably private area or room before breaking bad news with them. We were told that it was always possible to locate a suitable room for these discussions. Nurses were always available to help and support patients with information when they were in clinic.
- In main outpatients some band 5 staff nurses had completed extra training to support patients when they had received bad news. Where bad news was being shared with patients the nurse would sit through the consultation with the patient, be responsible for documenting what was said and how the patient had reacted, and be responsible for supporting the patient through the process. The nurse would take the person to a private room where they would check that the patient understood what they had been told, and establish with them the level of support they required.
- This role had been established as the department recognised that although patients were being supported by the Clinical Nurse Specialist (CNS) some patients required further support through the pathway and the Band 5 Nurse was able to offer this extra help and guidance.
- We observed staff in the fracture clinic waiting area managing a patient who was behaving aggressively and threatening to self-discharge. Staff were very respectful, clear in their communication and dealt with the conflict with confidence.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The outpatient service was not always responsive to patients' individual needs. Overall, not all patients were seen within the national waiting time target for waiting to be seen in a clinic. The department had in place an improvement plan which was designed to improve on the referral to treatment times (RTT), however this had been in place for a short time and the long term impact on RTT figures across the Trust could not be evidenced at the time of our inspection. The Trust were able to demonstrate that they were making inroads on the backlog of appointments in most specialities.

We observed some delays in patients being seen at their appointed time throughout the time we were onsite at the hospital in some clinics. Delays in clinics were explained to patients, with staff following a protocol which ensured that they told patients about clinic delays and the reasons for these and that they were kept informed and comfortable with beverages, and when required food. The department audited staff compliance with this protocol.

Ophthalmology had a backlog of follow up appointments which they had a strategic plan in place to address. Follow up appointments were rated by clinicians for urgency, these appointments were then managed through partial bookings and monitored for risk through weekly governance meetings.

Diagnostic imaging services at WHH had reporting radiographers who provided a 'hot reporting' service. This enabled patients to receive the appropriate care as a result of an investigation in a timely manner.

The centralised call centre which managed referrals across all outpatient locations had been vastly improved since our last inspection. Telephone systems had been updated and improved and staffing increased. The managers in this department were constantly reviewing performance data and had overhauled the referral to treatment pathway management to ensure a fairer system for patients who were now all given appointments in chronological order. The department was rolling out new procedures for the

booking of follow up appointments through a partial booking process. The Trust had so far rolled this out in ophthalmology and cardiology but planned to roll it out to all other specialities by the end of March 2017.

Complaints were being managed in line with Trust policy and staff were able to tell us how they had made service improvements as a result of complaints analysis.

Service planning and delivery to meet the needs of local people

- The hospital had a newly built procedures suite in the main outpatient's area. The suite was used for invasive procedures such as colposcopy procedures. The area had been well designed to meet with the requirements for the procedures that were performed, along with being designed to meet with service user's needs. For example, one procedure room was designed and equipped for bariatric patients.
- Fracture and orthopaedic clinics were not managed by main outpatients and were held in a space that was not appropriate for the requirements of the service. The main waiting area for this service was cramped, and hot with many patients standing. Some patients were standing on casts and crutches.
- Once called through to clinic patients were moved into six chairs in a tight corridor which were placed in two rows of three chairs opposite each other and did not allow patients with leg fractures to extend their legs. Staff had to step over these patients to get to treatment rooms and the plaster room. The area had no bariatric equipment such as chair because there would be no room to place them in an already cramped waiting area.
- Many patients complained to us about the cramped conditions in this waiting area during our inspection. Staff told us that they often had to deal with aggressive patients as a result of the conditions they had to wait in. We observed one patient being aggressive with staff because of the uncomfortable waiting area during our inspection.
- Staff told us that the waiting area had been on the risk register but had been removed when a business case had been submitted to move the fracture and orthopaedic clinics to a more suitable area. However, on the day of our inspection staff were informed that the business case to move the clinic had been put on hold as finances were not available to manage the refurbishments required.
- Patients told us they were allocated enough time with the doctors when they attended their appointments, and that their appointments were not rushed. Doctors were well informed about patients' medical history, and patients' medical records were available to doctors.
- The hospital audited the time that patients waited for their appointment and monitored trends in late running clinics. In the latest monthly audit of June 2015 at the Folkestone Hospital site 366 patients were seen in clinic. Of these patients 94.26% of patients were seen within 30 minutes, 4.37% were seen within 30-40 minutes, 1.09% were seen within 40-50 minutes and 0.27% were seen within 50-60 minutes. No patients had to wait above 60 minutes for their appointment. We are unable to compare this to results nationally as this data is not collected at all Trusts nationally. However, across the Trust the Folkestone site performed better than the other sites for patient waiting times.
- Staff in the department followed a 'Meet and Greet' protocol. Staff were required to pass competency assessments around this protocol before running clinics. The protocol told staff at what intervals to advise patients about waiting times and when to offer them refreshments or food. Matron had worked with staff who initially found it hard to go into a waiting room full of patients and explain to them the reasons for the clinic delay. The department demonstrated a commitment to keeping patients informed and comfortable during clinic delays.
- The matron met with divisional leads across all outpatient sites and planned capacity eight weeks in advance. They worked to ensure that all clinics were utilised as much as possible across all sites. Matron then communicated with the sisters to ensure that they can support this clinic activity with their staff and worked to ensure that staff were available for clinics that were required. Matron made it clear that their priority was to get the service delivered and to 'worry' about getting paid by the divisions at a later date.
- The audiology outpatients team managed their own referrals which came directly from GP's, internally through wards and via the Cancer pathway, the ear nose and throat(ENT) Team, and GP's with a special interest in ENT (usually symptoms like glue ear are referred this way) .The department also undertakes pre and post-operative hearing assessments where the

operation may affect hearing. We were told there were dementia champions in all audiology clinics across the trust. The manager was very proud that the service was the largest provider in East Kent.

Access and flow

- Hospital Episode Statistics for December 2013 – December 2014 showed that 294,780 outpatient appointments were made at WHH. We noted that 59% of patients attended their follow up appointment, with 33% attending their first appointment. The data showed that the hospital's ratio of follow-up to new appointments was lower than the England average. Out of the total appointments made, 1% had been cancelled by patients and 7% by the hospital. Both these figures were below the England average of 6% and 7% respectively.
- Staff managed patients not attending clinics (DNAs) by text reminders. Between December 2014 and December 2015 7% of patients at WWH did not attend their appointments, which is parallel with the England average of 7%. We were told by trust managers that the hospitals did not attend rate was continuously monitored to enable changes and adaptations to be made to minimise waste of resources. For example, texting had been used to remind patients of their appointment date and time. Measuring the non-attendance rate is important, because non-attendances mean that resources are not being used well and can have negative impact on patients receiving services at the hospital.
- WHH had piloted a DNA survey for one month where patients who had not attended their appointments were contacted to see if there was a trend in reasons why patients were not attending their appointments. We saw the results of this audit which did not raise a common reason for nonattendance.
- Part of the outpatients strategy was to improve RTT across the trust. This had been a problem for the trust at our last inspection. We were shown data which demonstrated that a robust monitoring and improvement plan was in place. The trust were able to demonstrate that they were making inroads on the backlog of appointments in most specialities.
- The trust had also improved their processes to ensure that patients were being given appointments in a fairer way. Previously the system of benchmarking patient pathways had meant that patients that breached the initial pathway could be placed out of date order meaning that patients who had entered the pathway after them could have received appointments before them. The new system ensured that patients on 18 week pathways were seen in strict chronological order.
- 95% of on non-admitted patients should start consultant-led treatment within 18 weeks of referral and 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral.
- Latest RTT times published by NHS England published on 9 July 2015 show that overall the Trust performed below the NHS standard of 92% with 88.4% of patients who had started their treatment within 18 weeks. These statistics are reported at Trust level and are not broken down by hospital site.
- More detailed analysis showed that the following specialities were performing below the NHS operating standard of 92%. general surgery 82.2%, urology 90.4%, trauma and orthopaedics 84.4%, ENT 88.2%, ophthalmology 90.1%, oral surgery 88.4%, gastroenterology 83.8%, dermatology 89.9%, thoracic medicine 91.4%, neurology 85.5%, and gynaecology 89.2%.
- Four specialities were performing above the NHS operating standard of 92%. these were general medicine 98.6%, cardiology 93.7%, rheumatology 95.4%, and geriatric medicine 89.2%.
- Of these statistics 6,247 patients were on the non-admitted treatment pathway (which involved only outpatient interventions). Of these patients half of them were seen within seven weeks, with 19 out of 20 patients starting their treatment within 20 weeks.
- Ophthalmology was highlighted as a service which was struggling to manage the demands on the service. As part of the ophthalmology strategy, the clinical teams put ophthalmology forward to be the first speciality to go with partial booking. As part of this programme, recording sub speciality was implemented. This allowed the service to focus on those areas that were in most need of capacity and allow the correct recruitment strategy to be developed to address the gap in clinical skills.
- Due to historic Patient Administration System (PAS), the true follow up capacity gap was not visible. Partial booking has given transparency to the issues facing follow ups which have been included within the ophthalmology business case. To date there are approximately 5,500 patients waiting for a follow up

appointment outside their required timeframe to be seen. Follow up capacity currently stands at 11,000 appointment slots from June until December 2015. Following further analysis the capacity is not within the correct sub speciality and there is now a requirement to reallocate resources within the teams. Additional weekend lists were addressing some of the capacity gap, with the recruitment of an outside company to provide additional nursing and technician support to the medical teams.

- It was anticipated that the business case would be approved in August 2015. Within this case there were three new consultants. Two of these will be recruited to emergency eye care, releasing the current consultants back into their sub speciality clinics. This will give an additional 2,480 appointments back to the sub speciality. In addition, the nature of the emergency eye care presentations will be addressed by consultants sub specialising in cornea conditions which will reduce consultant to consultant referrals as they will be able to deal with the condition on presentation.
- The third consultant will specialise in glaucoma disease which was also a high volume speciality. The trust had been working in partnership with the CCG to design a pathway for stable glaucoma which will allow follow up patients to be seen in their community rather than in an acute setting. The CCG were currently working through the implications to the community services.
- With the two new emergency eye care consultants will be additional outpatient capacity which will equate to approximately 252 outpatient slots.
- Since the inspection the Trust has confirmed that the business case for ophthalmology has been presented to the strategic investment group by the clinical lead where it was approved to be presented at management board in November.
- Part of this business case is to introduce virtual clinics for diabetic medical retina patients. The Trust have written a pathway for the CCG to transfer approximately 4000 stable glaucoma patients into the community.
- In the meantime the Trust have written a specification to go to tender for an external company to integrate with services to provide additional capacity. The department also currently have an outside company assisting with weekend capacity.
- The follow up waiting list was held on a system called EPR. The Trust are in the process of transferring the patients onto PAS and validating as part of the process. Part of this process is providing clinical validation for some of the lists such as orthoptics and contact lens patients.
- For each patient that requires a follow up appointment the clinician indicates the priority whether it is urgent, chronic or routine. The priority selection criteria was decided by the lead clinician.
- The departments governance team are monitoring the follow up list weekly with the operational team prioritising patients from the partial booking list as appropriate with risk being discussed at every governance board.
- The trust reported on cancer wait times trust wide. This data could not be broken down by hospital site. In quarter four 2014/15 93.9% of patients given an urgent referral by their GP on suspicion of cancer to the trust had their first consultation within two weeks of the referral as recommended. The trust was operating above the set operating standard of 93% for the two week cancer waiting times however it was operating slightly below the England average suggesting it was not operating as well as other trusts in England.
- In quarter four 2014/15 97.5% of patients given a decision to treat for cancer received their first treatment within 31 days of the decision. The Trust was operating above the set operating standard of 96% for the two week cancer waiting times it was also operating above the England average suggesting it was operating better than other trusts in England.
- In quarter four 2014/15 75.3% of patients given an urgent referral by their GP on suspicion of cancer to the trust received their first treatment within 62 days of the referral. The Trust is operating below the England average suggesting it is not operating as well as other trusts in England.
- All two week referrals went through the central booking office. Any breaches of the two week RTT went on a report that was circulated to divisional leads daily. Performance on cancer targets was also discussed at a weekly key performance indicator (KPI) meeting.
- There was an acknowledgement that endoscopy was struggling to meet with RTT targets. We were told that the trust had tightened up the escalation process in order to address the issues. However a lack of doctors in the trust able to perform endoscopic procedures put a

strain on the trust's ability to meet with the demand for this service. A national advertising campaign had meant that in June 2015 the trust had 2,400 two week referrals which was an increase of 200 on the previous month.

- Urology also struggled to meet cancer pathway targets due to several issues within the four separate pathways. There were issues with diagnostics within the pathways, in particular with biopsies relating to prostate cancers. The trust had a 10 day target for biopsy which was not currently being met. This Trust was currently breaching the 31 day RTT target by approximately 20 patients per month.
- Fracture and orthopaedic clinics had started virtual clinics to manage referrals through Accident and Emergency with minor injuries. Staff had visited another hospital site that were managing their service in this way and had bought back the learning from this to their own service. This had reduced the numbers of patients coming into clinics as consultants reviewed them and telephoned them with advice. This ensured that patients who did not require further review were discharged, and those needing an appointment were given one in the correct clinic.
- We observed radiographers reporting on investigations immediately in the diagnostic imaging department. This enabled the examination results could be delivered back to those who had requested it in a timely manner. However, there were some delays in reporting other diagnostic tests and at the time of reporting 733 examinations were awaiting report.
- The radiology manager told us they were managing waiting times in diagnostic imaging. At the time of reporting the average wait for x-ray was one day, MRI was 21 days, CT was 22 days and non obstetric ultrasound was 22 days. Overall this was less than the average wait times at the time of our inspection
- The Outpatients Booking Office managed calls and referrals for all of the outpatient locations in the trust and dealt with 76% of the trusts referrals with some specialities managing their own booking processes.
- The Outpatients Booking Office had four main functions. It operated as a call centre Monday to Friday 8am until 4pm, and was about to start operating as a call centre on a Saturday 8am until 4pm. It operated as a referral and booking centre for all the outpatient sites which included 'Choose and Book' referrals. It had a rapid access team which dealt exclusively with two week and cancer referrals and managed the Clinic Maintenance Team who set up clinics on the patient administration system (PAS), amended clinic templates, and cancelled and rebooked clinic appointments.
- Choose and Book referrals were directly bookable by patients who could access and book appointment slots by phone or online. They could also be booked indirectly by outpatient's booking office staff. If Choose and Book referrals could not be managed within 18 week timescales the system would alert staff who would go to the referrer and obtain a paper referral that could be managed outside the Choose and Book system.
- Once paper or fax referrals were received, clerks would date stamp the referral before booking the patient onto the system and sending the referral to the relevant consultant for triage. Managers told us that the expectation was that consultants would triage referrals within 48 hours; however this was not always happening. The manager of outpatients booking was working on a service level agreement which was at a draft stage at the time of our inspection. They hoped that once completed and agreed by specialties this document would have clear protocols and key performance indicators (KPIs) around the timeframes for triaging referrals.
- During triage referrals would be rated for urgency and then forwarded to the outpatients booking team to make the appointment. Urgent appointments were made within two to four weeks unless they were on the cancer pathway when an appointment was given within two weeks, and routine appointments were made within eighteen weeks. Central booking staff then booked appointments using the urgency scale. We were told that they would escalate to divisional leads if they could not make appointments within the agreed timescale.
- Where booking staff had escalated patients who they were unable to book within the timescales required, divisional managers would steer staff on how to manage these bookings. We were told that this would be addressed by providing extra clinics, converting follow up appointment slots into new appointments, double booking clinic spots or by agreeing breaches in the RTT.
- The call centre monitored the length of time it took for calls to be answered, the length of time calls took, and the number of people who ended the call before it was answered. By doing this they were able to monitor trends and ensure staffing levels in the department met

with the demand. The telephone systems had recently been upgraded to improve the services. The upgrade had created some initial snagging issues but these had been resolved.

- Main outpatients audited the number of referrals that had been scanned and registered on the electronic system within five days of receipt. Between March 2014 and April 2015 100% of referrals had been processed within five days against a target of 100%.
- Medical secretaries at the hospital were not consistently able to send GP letters following clinic appointments within the trust's policy timescale of three working days. On the day of our inspection respiratory medical secretaries were typing the letters from appointments on 1 July 2015 and stoma care were typing the letters from appointments on 9 July 2015. However, stoma care medical secretaries were able to meet with GP letter targets and were typing letters from appointments the previous day at the time of our inspection.
- We were told across all disciplines that urgent letters were typed immediately and always met the three day target. The medical secretaries told us that if a letter was urgent the consultant would mark it as such. The only examples we were given where a letter would not meet the timescale is if it had to go back to the medical staff for clarification. Dermatology told us that any urgent skin cancer letters were processed within 24 hours and they always met this target. We were shown evidence on the electronic system showed there were no outstanding urgent skin cancer letters on the day of our inspection.
- We were told that all letters for GP's were sent electronically and if a letter had been marked as urgent by the hospital doctors a separate email was also sent to the GP advising them that the letter had been sent.
- Due to recent changes to the processes around centralised booking the Respiratory and Stoma care services were on a new system whereby if a cancellation was within 8 weeks the patients that were being cancelled were sent to the clinic maintenance team with any follow up appointments going to the partial bookings team. The medical secretaries had little control over this process.
- The respiratory service had been on the system for three days and did not consider they had enough time to evaluate the effectiveness of these changes. Stoma care medical secretaries were different in that although they were on this system they had more flexibility to open up clinic appointments for cancelled patients at other hospitals or extra clinics at WHH.
- The dermatology service called patients directly to cancel and were able to re book the patient. If a patient was due for a follow up appointment this was made as they left the previous appointment at outpatient's reception. If the patient ran out of medication before this follow up appointment the dermatology secretaries would make every effort to ensure they moved the appointment.
- We were told that the department manager had prepared and presented a paper to the KPI meeting about the effects of late running and overbooking clinics had on the patient experience. The department manager felt it was much better now and felt they had been listened too.

Meeting people's individual needs

- Staff ensured that patients who may be distressed or confused by the outpatient environment were treated appropriately. Patients living with a learning disability or diagnosis of dementia were moved to the front of the clinic list. The outpatient staff liaised where needed with ambulance transport staff to ensure that this process ran smoothly.
- We were told that translation services could be accessed through language line for people whose first language was not English.
- Patients we spoke with were positive about the outpatient and diagnostic imaging services and told us they were satisfied with the treatment they received. Patients made positive comments about nursing staff, healthcare assistants, receptionists and doctors.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints would be dealt with by the outpatient matron. If the matron was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). Staff explained the complaints procedure to us.
- Complaints were discussed at departmental level and also at Directorate Clinical Governance Group meetings.

Outpatients and diagnostic imaging

There was evidence to show that lessons learned were shared with staff. Most of the staff we spoke with were able recall when actions from complaints were shared with them.

- Matron encouraged staff to contact them where a patient was complaining. They told us that they preferred this as they always got the 'whole picture' where they managed complaints like this. They could often resolve the problem more quickly if they dealt with it straight away. Staff gave a recent example of what appeared to be a simple complaint about the length of time it took to get an appointment but was in fact a far more complex complaint which matron was able to deal with within an hour of meeting with the complainant.
- As a whole the trust had received 239 contacts through the Trusts Patient Advice and Liaison Service (PALS) between April 2015 and June 2015, 70 of these had been at the WWH site. We looked at the reasons for these contacts but saw no apparent trend.

Are outpatient and diagnostic imaging services well-led?

Good

Outpatients had implemented an improvement strategy and a special measures action plan following our last inspection. Managers and staff working in the department understood the strategy and there was a real sense that staff were proud of the improvements that had been made. Progress with the strategy was monitored during weekly strategy meetings with the senior team and fed down to department staff through staff meetings and bulletins.

Staff were keen to show us areas that had been improved and this was particularly evident in outpatient's central booking and the health records management team.

Staff felt that outpatients was an area that the Trust Board were interested in and had invested in. Matron described the department as a progressive and important place to work, and had leased with Occupational Health to ensure that nurses who were not fit to work elsewhere in the hospital were not sent to outpatients believing it to be a less strenuous department to work it. Matron said, "I only want committed nurses in this department, who want to embrace the opportunities to learn and progress, it is such an interesting place to work".

The nursing care and management of nurses in the department was exceptional. The matron and sisters were very well thought of by their staff. Nursing staff were very clear on their roles and responsibilities and the direction that the department was going in.

Matron was very proud of her staff and the department's successes, but equally keen to drive improvement in the patient experience throughout the department, and share good practice in outpatient areas that were not directly managed by them.

There was an open culture in the department and we were given examples where Band 2 HCAs had challenged doctors and stopped clinic appointments where they were not happy with an aspect of care.

Vision and strategy for this service

- The trust had implemented a Special Measures Action plan following our last inspection. The action plan identified where issues had been raised during inspection and outlined actions to be taken by the trust along with an agreed timescale. This action plan had been RAG rated on delivery of objectives.
- Outpatients had implemented an improvement strategy. The outpatient clinical strategy objectives as approved by the board in June 2014 following public consultation were to reduce the number of facilities used for out-patient clinics from 15 to 6; WHH Ashford, KCH Canterbury, QEQM, Margate, RVH Folkestone, Dover and Estuary View Medical Centre. To offer a wide range of services across most specialties including diagnostic support. To extend clinic hours from 07.30 -19.00 and Saturday mornings to improve patient choice and access and make more effective use of staff time. To increase the number of people who are within a 20 minute drive of out-patient services. To invest in the clinical environment to support high quality clinical services and an improved patient experience. To develop a one-stop approach more widely than is currently seen in services. To expand the use of technology to reduce follow up appointments and support patients, monitoring their progress at home or in Primary Care; and to invest £455,000 in extending / modify public transport routes provided by Stagecoach.
- Progress with the strategy was monitored during weekly strategy meetings with the senior team.
- Outpatient had a business plan in place for 2015/2016. This outlined the streamlining of services from 15

outpatient locations to six, a review of 18 week and two week pathways with a strategy for meeting a rise in demand, a review of current work streams and their purpose, a market assessment and planned developments.
- Outpatients had a Patient Administration Review Project Group whose main objectives were to review all patient administration services in order to deliver an efficient patient pathway that complied with national and trust access standards, and delivered an improved experience and access for patients. We were shown examples of improvements that had been made to the service as a result.

Governance, risk management and quality measurement

- Risk and Governance meetings were held monthly which were attended by managers throughout the outpatient and diagnostic imaging departments. The outcomes from these meetings were shared with staff during staff meetings and matron devised a monthly highlight report for staff which summarised the clinical governance report and highlighted learning from incidents and complaints. This went to all departments and was pinned on staff notice boards.
- We saw local risk registers for directorates that included the outpatients and diagnostic imaging department, which enabled the Corporate Governance Group to understand the most significant risks and approve action to mitigate those risks.
- There were regular team meetings to discuss issues, concerns and complaints across the division.
- The trust undertook clinical audits such as hand hygiene, infection control, sharps, resuscitation equipment and records of the audits showed a high percentage of compliance with good practice.
- The trust also audited referral to treatment pathways, call centre statistics, meet and greet protocols and clinic waiting times in order to monitor patient experiences through the department.
- The results of these audits were fed back through leadership meetings, clinical governance meetings, staff meetings, and patient user groups to ensure that service improvements were made where indicated.

Leadership of service

- We found competent staff managing each of the clinical areas visited. Staff told us that they had confidence in the people managing them and the leadership within the department. Staff showed a good understanding of the values and vision of the trust and felt able to raise concerns.
- The matron had worked hard to ensure that processes were identical across all main outpatient locations. This meant that nurses could work across sites as there was consistency in both processes and expectations of them. Other outpatient clinics which were run by other divisions such as ophthalmology had recently started to use the meet and greet competencies that had been used in main outpatients. The matron was starting to work with matrons in other clinics to share good practice and encourage joint learning.
- The matron and sisters were spoken of very highly by staff who felt well supported by them.
- There were clear lines of accountability and responsibility within the outpatients and diagnostic imaging department. Staff in all areas stated that they were well supported by their managers, that their managers were visible and provided clear leadership.
- Staff felt optimistic following the arrival of the interim Chief Executive.
- Band 7 sisters had been offered places on the leadership programme. This programme assisted them in their development as managers.
- Matron took part in a 360 degree appraisal programme which they used to improve on their ability as a leader. Due to the success of this approach matron was planning to implement this style of appraisal for the Band 7 sisters in the department also.

Culture within the service

- There was a positive culture amongst staff; staff were committed to and proud of their work. Quality and patient experience was seen as a priority and everyone's responsibility.
- All the staff we spoke with in outpatient and diagnostic imaging departments told us that communication between different professionals was good and that it helped to promote a positive culture within the departments. Staff described a very positive working environment. Clinical staff we spoke with told us they felt able to raise concerns and discuss issues with the managers of the department. All staff we spoke with

were professional, open and honest, and were positive about working at the hospital. Staff acted in a professional manner, they were polite and honest and respectful.

- Matron was very proud of the department and the staff who worked there. They had worked hard to ensure that staff saw it as a progressive and innovative place to work and learn. Matron had worked with Occupational Health to ensure that nurses were no sent to the department with health related problems, wrongfully believing that it was a quieter place to work.
- We were given examples of where staff had felt able to speak out and raise concerns. We were told that a Band 2 HCA had stopped two new doctors from accessing the computer systems when they didn't have ID on them. We were also given an example of a Band 2 HCA stopping a clinic where they felt someone with a learning disability did not have the understanding to consent and didn't have an advocate with them to assist with the situation.
- All staff in main outpatients had been involved in the 'Wellbeing Programme'. Staff attended sessions where they were involved in discussions around subjects such as weight loss and stress. From this staff were able to self-refer themselves for further assistance.
- Staff were aware of the confidential staff counselling service available to them.
- Matron and sisters were mindful of the stress that staff could be under in particular with the changes to the services. They had encouraged staff to complete stress awareness assessments and had referred staff to occupational health where these had established the need for further assistance.
- One module of the customer care training attended by all main outpatient staff was entitled, 'Our customer, our responsibility'. This ethos was fed in part throughout each module of the programme. The training taught staff to see all people entering the hospital as their customers and their responsibility. Staff therefore did not ignore the needs of patients or visitors attending other areas of the hospital.
- We saw evidence that this ethos was embedded in the way that staff treated people entering the department throughout our visit. Matron gave an example where one of the outpatient nurses had found a patient alone waiting for transport, and had stayed with them until they had been collected at 9pm. This was despite the patient not visiting outpatients but having been at the hospital for another reason.
- Matron also described reception staff noticing an increase in patients attending the hospital because they had been unable to access the call centre. Staff had raised this and matron had contacted the call centre immediately to get the issue resolved.

Public engagement

- Speakers attended the user group meeting routinely to discuss other departments within the hospital. The patient user group at WHH recently toured the laboratories and had a talk from this department.
- Outpatients held quarterly user group meetings where people who had used outpatients were able to involve themselves in improvements to services. The group had been involved for example with collecting patient views around facilities and had as a result of this obtained some higher back chairs for improved comfort of patients attending clinics.
- The current survey being managed by the group was around how long patients would wait after hearing that their appointment had been cancelled, to contacting the department if they hadn't received an appointment to replace it. From this survey the group will look at the wording in appointment letters to reflect their findings.
- Patient user group members were involved in the walk the floor audit where they were able to monitor the care and environment and make suggestions for improvement.
- The users group was currently advertising for more patient representatives. Matron actively recruited patients who had made a complaint about the department to join the group, and gave an example of a patient representative with hearing difficulties who had greatly improved the facilities and awareness in the department around this disability.

Staff engagement

- In order that staff felt included and well informed about the strategy each member of staff had received a letter which included a description of the strategy and how it affected them**.** Staff were able to confidently discuss their progress on service improvements along with areas that had been identified as still requiring improvement.

Outpatients and diagnostic imaging

- Staff we spoke with said they felt engaged with the trust and could share ideas or concerns within their peer group and with their managers. Staff were given trust messages directly via email, and through bulletins and on screen savers. Staff we spoke with said they felt well informed of developments and issues within the hospital and the wider trust in general.
- In the most recent staff excellence awards the first three places were awarded to staff from the outpatients department. First place was awarded to an HCA, second place to an associate practitioner, and third place to an administrator. The staff were proud of this achievement and felt that it was reflective of staff commitment within the department to deliver a high standard of patient care.
- Exceptions to this were in fracture clinic where staff had worked hard on a proposal to improve the environment within this clinic. One staff member had heard a rumour that this proposal had been put on hold/rejected for a second time. They raised concerns over this with us during the inspection. The matron and consultant on site had not heard that the project had been put on hold. However, a service manager when asked came to the department and confirmed that the rumour was correct. This demonstrated poor communication with staff who were extremely disappointed at this outcome.
- In ophthalmology we spoke with two consultants who were concerned about the management of referral into the service and capacity issues. When we spoke with the leads of the service we found that the information that they gave us regarding strategy, vision, and management of RTTs within the service would have been helpful information for the consultants to understand. Therefore in this instance the trust had failed to provide staff with adequate information.

Innovation, improvement and sustainability

- Following learning from a patient who developed a pressure injury under their cast a staff member in fracture clinic had developed a booklet for staff explaining the risks associated with casts and splints, the complications of fractures, leg elevation, and care of patients with braces and collars in situ.
- Staff in fracture clinic had also developed a learning package and competency assessment for staff caring for patients with a spinal injury and the care of patients with a Miami J Cervical Collar in situ. This training had been shared across the other hospital sites.
- Ophthalmology were a service that had been identified by the Trust as experiencing difficulties meeting patient demand and requiring improvement. As a result a teams was formed for each of the services who worked to develop recommendations that increased capacity, efficiency and flexibility. The overall vision for the service transformation that would be driven by the ophthalmology strategy was expressed as, “An agile service with the capability and capacity to meet demand pressures, whilst providing excellent and sustainable care for our patients”.
- From the respective teams’ output an overall transformation strategy for the whole ophthalmology service was developed. The transformation strategy involved an increase in staff numbers and new equipment to support these staff. The strategy takes advantage in the changes to outpatient facilities being driven by the outpatient clinical strategy, and new facilities at Dover hospital and Estuary View, ensuring efficient use of these facilities and maximising patient throughput.
- The strategy also recommends the introduction of an electronic patient record system in the form of software which will drive both efficiency increases and cost savings. The system can also be rolled out to, and integrated with, community services to support the flow of patients in and out of acute services. Ophthalmology was successful in obtaining external funding to commence this project commencing this financial year.
- In order to improve patient experience and choice the outpatient improvement team had made changes to the ways in which follow up appointments were being made in some speciality groups. The changes were made to enhance patient experience by reducing the number of times follow up appointments are cancelled and rebooked, to optimise capacity, and improve on outpatient efficiency. On the 15 December 2014 outpatients launched partial booking within the Trust with the ophthalmology specialty. In June 2015

cardiology started partial booking with a full evaluation and lessons learnt exercise being undertaken at the time of our inspection. The Trust had set itself a target to complete roll out of partial booking by end March 2017.

- As a result ophthalmology had started to use a partial booking system to book patients for follow up appointments. The Trust had produced a flow chart for staff to follow when booking these appointments which included the escalation system where appointments could not be booked within the timescales required. Secretaries told us that the initial issues with the system were an increase in calls from regular patients who didn't understand the changes in the way that their follow up appointments were managed.
- The outpatient's improvements programme had also recently instigated changes to the follow up booking protocol for out-patient cardiology. Any patient leaving clinic whose clinician had requested they be seen again in outpatients within the next 8 weeks would have their appointment made prior to them leaving the hospital. Any patient leaving clinic whose clinician had requested they be seen again in outpatients any time after 8 weeks would be added to a waiting list. The clinician would also have to identify (via the outcome form) the category of the patient. Category 1 – Urgent Pathway, Category 3 – Routine, and Category 4 – SOS (discharged but can ring if in problems within six months). The protocol described the process and included a flow chart for staff to follow.
- Outpatients were piloting the accredited Ward /Department developed in collaboration with the Trust wide Ophthalmology Matron. The programme helped staff to look critically at their service along with celebrating good patient care. This programme was being piloted at WHH and QEQM but was about to be rolled out to other outpatient locations.

Outstanding practice and areas for improvement

Outstanding practice

- The outpatient improvement plan had improved the service for patients. The team managing these improvements had regular meetings to establish their progress whilst ensuring staff were informed about improvements being made and the reasons behind any changed to the service.
- The management of health records and the central call centre had improved at a fast pace since our last inspection and we felt assured that these improvements would continue.
- The Nurse leadership in outpatients was outstanding with staff inspired to provide a good service to patients. The main outpatient's matron provided knowledgeable and inspirational support to staff whilst working hard to maintain and improve the service.

Areas for improvement

Action the hospital MUST take to improve

1. There must be sufficient numbers of suitably qualified, skilled, and experienced midwifery staff available to deliver safe patient care in a timely manner.
2. The environment and facilities in which patients are cared for must be safe, well maintained, fit for purpose and meet with current best practice standards.
3. There must be sufficient equipment in place to enable the safe delivery of care and treatment, that the equipment is regularly maintained and fit for purpose to reduce the risk to patients and staff.
4. The trust must ensure the hospital has sufficient capacity to cope with the number of women in labour and new born babies on a day to day basis.
5. The wards must be supported in providing a full seven day service by appropriate numbers of support services such as radiology, physiotherapy and pharmacy.
6. There must be robust systems in place to monitor the safe management of medicines to ensure that national guidelines are reviewed appropriately and their implementation monitored.
7. The trust must ensure that all taps in clinical rooms are working effectively.
8. The trust should ensure that clinical areas are not carpeted. Where clinical areas are carpeted they must be managed with effective risk assessment and cleaning regimes.
9. The trust must ensure that staff have the knowledge and skills required to comply with the organisational systems and processes for consistent incident reporting.
10. The trust must seek and act on feedback from patients, families and carers for end of life care services.
11. There must be sufficient numbers of suitably qualified, competent, skilled and experienced end of life care staff to ensure the quality of service for all end of life care patients seven days a week.

Action the hospital SHOULD take to improve

- Review the training provided to clinical staff on the Mental Capacity Act and DoLS to ensure all staff understand the relevance of this in relation to their work.
- The trust should ensure that surgical staff undertake required training in safety related subjects.
- The trust should continue to improve referral to treatment times across all specialities to ensure that patients are treated in an acceptable timeframe following referral to the service.
- Standardising inotropic infusions to avoid the risk of potential drug errors when staff engage in cross site working.
- There should be a formal vision and strategy for women's health services to enable the development of

Outstanding practice and areas for improvement

a modern maternity service which is woman centred, underpinned by a sound evidence base and benchmarked against best practice standards. This should include a review of environmental issues.
- Methods of maintaining the stability of leadership within the maternity department should be established.
- The routine administrative burden on maternity staff at weekends and out of hours should be reduced in order to free midwifery staff to look after patients.
- Staff should be encouraged to report non-clinical incidents in order that action can be taken to protect patients from avoidable harm.
- The electronic system for allocating NHS numbers to new born babies should be functioning, in order to avoid the risk of babies missing screening tests through a manual process with insufficient printers available.
- There should be a robust system in place to measure, monitor and analyse common causes of harm to women during pregnancy and childbirth.
- The trust should continue to improve Referral to Treatment times across all specialities to ensure that patients are treated in an acceptable timeframe following referral to the service.
- The trust should ensure patients are identified as at end of life promptly.
- The trust should improve advance planning for end of life care patients that includes a replacement for the Liverpool Care Pathway that will reflect their needs and preferences.
- The trust should ensure that joint training with contracted services is in line with best practice and trust policies. Relevant staff should be involved and consulted.
- The trust should ensure that end of life care documentation on the wards is up to date and accurate.
- The trust should ensure clear executive leadership and trust board strategy for end of life care.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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